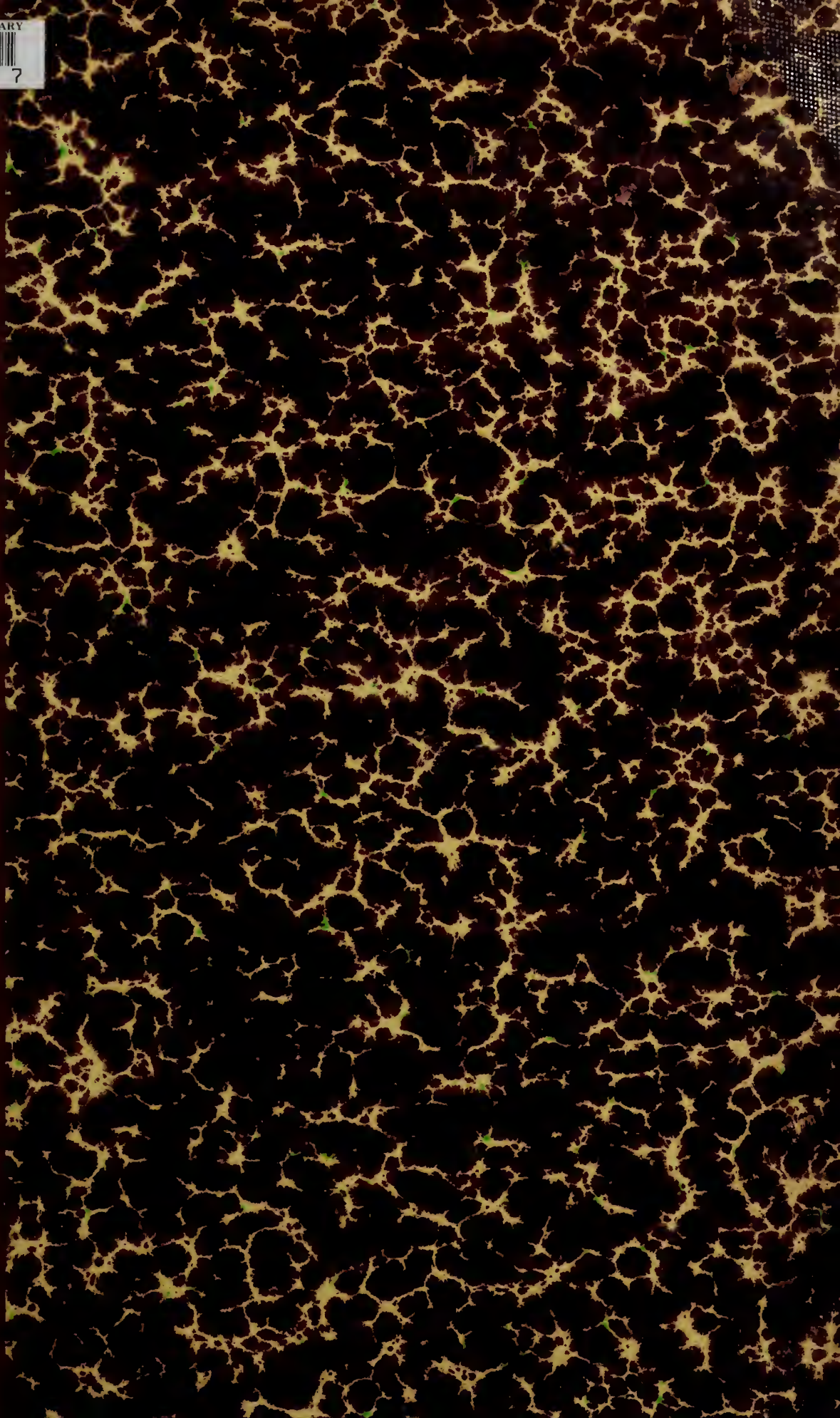


COUNTWAY LIBRARY



HC 3ISF 7

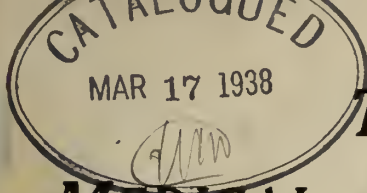


BOSTON  
MEDICAL LIBRARY  
8 THE FENWAY









# THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

Owned and Controlled by the Medical Association of Georgia  
PUBLISHED MONTHLY under direction of the Council

Number 1  
Volume XIV

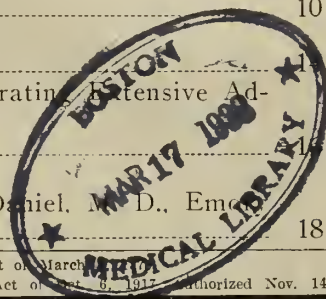
Atlanta, Ga., January, 1925

Per Year : : \$3.00  
Single Copy 30 Cents

## TABLE OF CONTENTS

### Original Articles

	Page
My Ideals for the Medical Association of Georgia— J. O. Elrod, M. D., President, Forsyth.....	1
A Definite Program for 1925— F. C. Warnshuis, M. D., Chairman, House of Delegates of the A. M. A.....	4
Statewide Health Association— C. H. Richardson, Jr., M. D., Macon.....	7
Program of the State Board of Health— J. P. Bowdoin, M. D., Adairsville.....	10
Tips for the Cock-Sure Specialist— Elton S. Osborne, M. D., Savannah.....	
Omental Grafts as a Means of Relief After Liberating Extensive Ad- hesions in Abdomen— E. C. Davis, M. D., Atlanta.....	
A Case of Heart-Block with Recovery— George Bachmann, M. D., and Walter W. Daniel, M. D., Emory University.....	18



Entered at the Postoffice at Atlanta, Ga. under the Act of March 3, 1879, authorized Nov. 14, 1918.  
Acceptance for mailing at the special rate of postage provided for in Section 1103, Act of Oct. 3, 1917.

# CALCREOSE

POWDER  
TABLETS  
SOLUTION



## CALCIUM AND TUBERCULOSIS

CALCIUM starvation has been suggested by phthisiologists as a factor in the etiology of pulmonary tuberculosis. By prescribing **CALCREOSE** some of the needed calcium may be supplied.

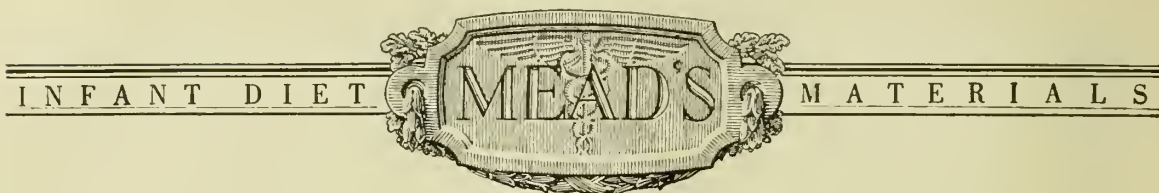
**CALCREOSE** (calcium creosotate) is a mixture containing in loose chemical combination approximately equal weights of creosote and lime. It has the pharmacologic activity of creosote as used in the adjuvant treatment of tuberculosis, but differs from creosote in that it apparently does not have any untoward effect on the stomach.

*Samples of Tablets on Request*

THE MALTBIÉ CHEMICAL COMPANY

Newark, New Jersey





# INFANT FEEDING

*THE PHYSICIAN HIMSELF is the most important factor in the successful feeding of infants.*

BUT TWO OTHER FACTORS ENTER into the equation—

THE MOST IMPORTANT BEING the physician's control of the case;

AND NEXT IN IMPORTANCE the reliability of his infant diet materials.

MEAD'S INFANT DIET MATERIALS satisfy this last requirement. They are as reliable as it is possible for us to make them;

BUT THEIR INDIRECT INFLUENCE on the other requirement, the doctor's control over the feeding case, is even of greater value.

MEAD'S INFANT DIET MATERIALS are marketed to the laity only on the physician's prescription—No feeding directions accompany trade packages—The mother gets her information only from the doctor who changes the feedings from time to time to meet the nutritional requirements of the growing baby. *He therefore CONTROLS the case.*

THE PHYSICIAN can, with three MEAD diet materials, plus his skill and his control, satisfy the nutritional requirements of nearly all infants entrusted to his care.

MEAD'S DEXTRI-MALTOSE (carbohydrate) cow's milk and water, combined in proportions to suit the individual baby, meets successfully the requirements of most infants.

FOR OTHER INFANTS where additional carbohydrate is not indicated but additional protein is indicated (such as in Diarrhoea, Marasmus, Colic in breast-fed infants, etc.), the use of CASEC (protein) in the cow's milk modification gives gratifying results.

MEAD'S COD LIVER OIL, a standardized antirachitic agent of known potency, protects all infants, whether breast or bottle fed, from Rickets and can be given in such small doses as not to upset the fat proportion of the baby's diet.

*Samples and literature describing these three diet materials*

MEAD'S DEXTRI-MALTOSE • MEAD'S STANDARDIZED COD LIVER OIL  
MEAD'S CASEC      *Sent at the physician's request*



MEAD JOHNSON & COMPANY  
MAKERS OF INFANT DIET MATERIALS  
EVANSVILLE, INDIANA, U. S. A.



MEAD'S DEXTRI-MALTOSE

# **THE JOURNAL**

## **OF THE**

# **MEDICAL ASSOCIATION OF GEORGIA**

DEVOTED TO THE WELFARE OF THE MEDICAL PROFESSION OF GEORGIA

PUBLISHED MONTHLY under direction of the Council

---

Volume XIV

Atlanta, Ga., January, 1925

No. 1

---

## **Original Articles**

---

### **MY IDEALS FOR THE MEDICAL ASSOCIATION OF GEORGIA**

**J. O. Elrod, M. D., President,  
Medical Association of Georgia,  
Forsyth, Ga.**

First, that every County in the State be organized in some way.

Second, that we have a hundred per cent membership of eligible physicians in the State.

Third, that we maintain and publish the best Medical Journal of any state in the Union.

Fourth, that our Medical Defense Committee have fewer damage suits to defend every year.

Fifth, that our Association will be strong enough to educate the public through its membership of the dangers of cults and charlatans, until the public will drive the last of them from the borders of our State.

Sixth, that our Association through our Public Policy and Legislation Committee may be able to convince the State Legislative bodies that our organization should be consulted in regard to Health laws and appropriations.

Why should we have every County in the State organized? The County Society is the only portal of entrance to any Medical Organization. Why? Because the physicians in each county know the character of and qualifications of the other physicians in their county better than any committee from a State or a National Organization

could possibly find out. A County Society, being the portal of entrance to all other Medical Organizations, may be able to make an upright ethical practitioner of a physician who might be inclined to be unethical in many ways. In this way fraternalism will be promoted among all the physicians in a county, whereby their strength in health matters will be a power, where combined efforts will not allow criticism. The County Society should have public meetings dealing with Health subjects and if any physician in a community or county does not take some part in these meetings, the public begins to inquire why he is not affiliated with his County Society. Times have changed; there was a time when to be a member of a Medical Society was to belong to a Trust, but today the public demands that you keep abreast with the times and they realize that to do this you must belong to your various medical organizations.

We are not advertising when we have public meetings; they are always for the good of the county where they are held. The programs should be varied, consisting of scientific papers pertaining to Public Health, possibly a talk by some prominent layman. In connection with all this there should be some social affair. The above outlined program will keep your County Society an interesting one and will educate the public in health matters. I realize that this cannot be carried out in some counties in our State as in some there is only one physician and in others only two or three phy-

sicians. In this case two or more counties may combine and have a live organization. Your church, your social or golf club does not pay you a cash monthly dividend; you get out of either of them just what you put into them; but your County Society, which you help to keep active, will contribute to your success in every phase of life, whether religious, business or social. Your County Society pays back to you just what you put into it; if you do not attend and take interest you get nothing from the society. Each county society should have an active Secretary, for the Secretary means more to the success of the society than any other member. He should be a man who is not easily discouraged, so if one meeting is a failure he will not give up, but try harder to make the next meeting a success. The members should stand by their Secretary by giving him every support possible.

When every county in a District does its best and maintains a good society, your District Society will be a success and be a great benefit to all, but more to some physicians who may not be able for some reason to attend the State meetings. I wish at this time to appeal to every County Society that has not held its December meeting to call a meeting at the earliest possible date, elect officers, collect dues and report the meeting to our Secretary with accurate information as called for on the report blanks mailed out by him. This will give him an accurate directory of the State. Remember also that it is just as easy to pay your dues now as later and helps our Secretary a great deal in getting his files in order without a rush before April the first, as this is the last day you have to pay them and receive the protection of the Medical Defense feature of our State Association.

The Second Ideal depends on what I have already said in regard to the county societies, as the membership of the Medical Association of Georgia depends on the activity of its County Societies. The average percentage of membership in the United States is about 60 per cent, our average at present is 54 per cent. Georgia stands twelfth as to number in the states, seven-

teenth as to total number belonging to State organizations, but lamentably forty-third in percentage. States that are lower in percentage are Arkansas 51.9 per cent, Oregon, 50.8 per cent, New Mexico 50.4 per cent, Florida 38.1 per cent, District of Columbia 26.3 per cent. Our border states Tennessee 53 per cent, South Carolina 66.9 per cent, Alabama 78.8 per cent, Florida 38.1 per cent, North Carolina 74.3 per cent; Florida being the only one lower than Georgia. Why this state of affairs? We offer more for dues of \$5.00 than any other State; Organization, Medical Journal and Medical Defense. Why is it every physician is not a member? Is it, first, Ignorance of benefits; second, Indifference; or, third, Have we more quacks or ineligible physicians than other states? I am inclined to think the first classification prevails. Then if this is true you who know the benefits of our State Organization must be missionaries and explain the many benefits to your brother practitioner, who is not a member. First, the fellowship which we gain by being members together and associating with each other; Second, the knowledge which we obtain from scientific papers read at the meetings and printed in our Journal, as well as the personal exchange of ideas while in personal conversation; Third, the influence which being a member of the various organizations may give you with the general public. Our organization is able to promote Public Health ideas with a combined profession which does not allow criticism.

Our Medical Journal is one of the best in the Southern states.

The Medical Defense feature of our Association, which is the best protection any physician can have from damage suits, is one of the greatest benefits derived from being a member, especially if measured in a financial way. During my time as President of our Association I have found from visiting the various District Society meetings, that a good number of members do not realize they are being protected by this feature of the Association. A full explanation of the protection that is given you by our Association is printed on the back of your



membership card. I think it might not be amiss at this time to tell you of the work this Committee on Medical Defense has done since 1920. They have had seventy-seven suits brought against our members, which amounted to \$1,500,000 in claims. They have settled fifty-five of these claims with only one member having to pay any damages, the amount he paid being \$35.00, which he said he had rather pay than have to attend court. This case cost our Association \$400.00 besides the services of our regular paid Attorneys, with no expense to the defendant except the \$35.00 damages which he paid. They still have twenty-two cases pending, which amount to \$250,000. The Committee hopes to settle a good number of these cases out of court as they did in the fifty-five they have settled. The protection is worth a great deal more to you than protection by an Indemnity Company, which would cost you several times the amount of your dues to the Medical Association of Georgia. Should you have a damage suit before the majority of juries and they know that you are protected by some Indemnity Company, they would say, "Oh, we will give that fellow some damages, it will not cost that doctor anything," never considering how much they are damaging your reputation. On the other hand if they know that the entire Medical Association of Georgia is defending your reputation and that if any damages are awarded you will be the loser both financially and in reputation they will be more careful in rendering a verdict. To have this protection your dues must be received by the Secretary of the Medical Association of Georgia before April the first of each year. If you have paid your dues and do not receive your membership card within a reasonable time you should write our Secretary, as he is always very prompt to mail out membership cards when dues have been received. To be sure of your protection pay your dues at once, procrastination is responsible for a great many losses.

The Third Ideal, I trust we will all do our best the coming year to make good. How can we do this? By sending in all news items that may be of interest to the

physicians of our State, personals, public health items, notice of Society meetings, including programs, etc. Send in well written scientific papers. We can help in a financial way by helping the advertising department. Inquire of salesmen who call on you if their company carries an Ad with our Journal, try to buy from those who do advertise in our Journal and mention their Ad when ordering from them. Remember it takes all of these things to make a good Medical Journal.

My Fourth Ideal may be achieved by every physician being careful not to criticise his brother practitioner. So often a damage suit is brought against a physician on account of a thoughtless remark of a brother practitioner, who did not intend any damage or criticism when he spoke unthoughtfully. In this connection some of the suits we have had to defend have been against some of our best standing members and brought on on account of the criticism of some thoughtless physician.

The Fifth Ideal can only be achieved by County Societies having Public Health meetings, by writing Public Health articles for your County paper signed by your County Society. By every member of the County Society offering his support to the different lay bodies. If we do not do this the Quacks, Chiropractors and different Cults are going to get on the program of every lay body possible. Unless these lay bodies are told of this danger how are they to know who to choose for their programs?

How are we to accomplish the Sixth Ideal? First, by having a live, good-working Committee on Public Health and Legislation, which I think we have at present. In the past this committee has never had a chance to do any work, a new Committee being appointed every May just before the Legislature convened in June. The revision of our Constitution and By-Laws made this Committee a perpetuating Committee; the Chairman being appointed for three years with a new member appointed each year. This Committee can now lay out plans for Public Health Legislation and keep the members of the Association posted in advance

what legislation is coming up at the present session of our Legislative bodies. Then by every physician conferring with his Representative and Senator before they leave home to attend these meetings good can be accomplished. Especially should the family physician of these Representatives make a personal appeal to them and show them that any legislation we may ask for will be for the betterment and protection of the health of the State, which is the greatest asset we can have. The United States Government statistics show that Georgia's death rate for 1923 was the lowest of any state in the south-east, being 11.3 per thousand population. Since we are improving along this line let's not lag in our efforts to continue to lower the percentage. When we can show a low death rate and a healthful state then Industries will begin to flock to Georgia, especially since the people of Georgia have voted to exempt them from taxation for five years.

Our State Organization is incorporated under the laws of Georgia, every member has the same amount of stock in the Organization, every member should have the same amount of interest in the Organization to make it a success, as the members are the stockholders, our Councillors are our Trustees, and our Officers are our directors. Our Officers and Councillors are anxious to have the best Association in 1925 that we have ever had and that we will continue to grow until the second Ideal of your President is realized. What will you do? Will you do your part towards making your County a 100 per cent membership of eligible physicians? Speak to those who are eligible and are not members of your Society, explain the many benefits to them. Their membership will help the public and all the physicians in your County as well as strengthen our State Organization in every respect. The officers of our Association stand ready to help you in any way they can, so call on us when we can be of service to you.

## A DEFINITE PROGRAM FOR 1925\*

Frederick C. Warnshuis, M. D.,  
Chairman, House of Delegates, A. M. A.,  
Grand Rapids, Mich.

Before I address myself to the subject assigned, I wish to make it quite clear that I have not the desire to pose as a director or an authority. The suggestions that will be presented represent present conclusions that have been reached. They are advanced for the purpose of submitting a basis from which, by our combined experiences, judgment and discussion, it is hoped that a desired outline of uniform activity for 1925 may result.

For some twelve years I have been privileged to attend these annual conferences. That they are valuable has long since been established. That good has come from them is attested to. In my administrative work I have derived much that has been of value and assistance. The acquaintanceship that has been fostered I prize most highly. However, in spite of these acknowledged benefits there has been growing on me a feeling that is hard to put aside, that we as state secretaries are not obtaining all that can and should result from these annual meetings. Are we profiting as we should? Are our component state units and our American Medical Association neglecting an opportunity?

Organization and organized effort succeed just so far as they meet up to the principles that inspire and govern their existence. It is these principles that determine prestige and accomplishments. It follows that unless these principles and policies are comprehensive, the purposes and achievements of an organization or association will be narrow and limited or broad and inclusive. If we are to attain the greatest ends, achieve the greatest good and contribute a maximum amount of assistance to our membership and the public at large, it is quite essential and important that our principles and purposes shall include certain definite and basic objects that are ex-

\*Read before the Annual Conference of Secretaries of Constituent State Medical Associations, Chicago, Nov. 21-22, 1924.



pressed in a program to guide our individual and collective efforts in a uniform execution of them by each component unit, thereby establishing a national program of sustained action.

#### Four Objectives

I have frequently, and for a long period of time, meditated on this problem. I have reviewed, criticized and appraised our scheme of organization, the work that was being done and the results that were being obtained. I have endeavored to analyze them, diligently seeking to determine what were and what were not basic fundamentals. The quest has been to sift out and to formulate in concrete terms primal objects to justify, inspire and direct our work. The result of this study and thought has been the formulation of four principles that are expressive of desirable objectives that we as county, state and national units should seek to attain. They are advanced at this time with considerable hesitation. I purpose to outline in some detail the first principle as to definite recommendation that it comprise our program for 1925. The terms used to express these definite objectives are simple, but lend themselves to broad interpretation and are:

1. Acquaintance—to bring about understanding.
2. Fellowship—to establish good will.
3. Friendship—to encourage brotherhood.
4. Education—to increase individual efficiency.

At first thought, one will hesitate to accept this as the first fundamental object that is basic for our organized existence and work. Permit me to enlarge on all that is included in the term acquaintance, and what can be made to result from an acquaintanceship that is employed to bring about understanding.

Membership is fundamental; that will be acknowledged. The last annual report of our Secretary imparts that there are 145,966 graduates of medicine in this country. He further imparts that there are 3,047 county medical societies and that these county societies comprise our component state socie-

ties and have a membership of 90,056 physicians. That the total Fellowship of the American Medical Association was 51,063, April 1, and is now more than 55,000. These figures furnish much for thought, if one analyzes them. The query is pertinent: Why, of the total number of physicians in this country, are there only 90,056 members of county societies and why are only 56.8 per cent of these county society members Fellows of the American Medical Association? Is not the answer lack of acquaintanceship? Acquaintanceship with the principles and purposes that our organizations are based on and what they are attempting and how they are and can be of greater value to the individual physician if he but knew—had acquaintanceship with our work and more intimate contact with that which is being done. You and certain others know what we are striving for. Now reflect on that large number of practitioners who are totally ignorant, uninformed and misinformed. Go back to your own state, your own county, your own city and recall how many of the physicians that you are in more or less contact with who are in great ignorance regarding the work of your state society and who know nothing as to the American Medical Association.

There can be no argument as to our plan of organization, what has been attained and our future quests. We who know are justly proud of it. We point with proper pride to that which has been wrought, to the efforts that have been expended and to the splendid manner in which our officers and executives have performed the duties that have been entrusted to them. We are elated with these headquarters and the spirit that emanates from them. But—we are in a minority, for 50,000 physicians are uninformed on the subject, and among the 90,056 physicians who are members of state societies some 40,000 are in partial or complete ignorance. Were this ignorance dispelled, I am certain that our state and national membership enrolment would advance to if not exceed the 100,000 mark. I hasten at this time to add that I am not advancing numerical membership as the final and most



desired end of organization. Numerical strength is not and should not be our goal. Numerical strength should be sought only as an index that attests to the justification of existence. I might continue to enlarge further on this first foundation principle of acquaintanceship, for it lends itself to broad interpretation and application. I shall desist doing so and concern myself from now on with its application to being our definite program for 1925.

How shall it be applied? Here again I shall for brevity's sake set forth in table form:

Acquaintanceship—to bring about understanding.

A. Of the American Medical Association:

1. Its history and development.
2. Plan of organization, its constitution and by-laws.
3. Administration:
  - (a) Official personnel.
  - (b) Work and achievements.
  - (d) Service it renders to the physician.
4. The Journal and other publications.
5. Requirements for Fellowship.
6. Benefits of Fellowship.

B. State society:

1. Organization.
2. Officers and council.
3. Activities.
4. Membership relationship.
5. Membership qualifications and benefits.

C. Individual responsibility to:

- (a) County, state and A. M. A. Organizations.
- (b) Fellow practitioners.
- (c) Community.
- (d) Humanity.

**The Program**

This is the definite program that I submit for 1925. That we as state officers and editors of medical journals convey this information, this knowledge, if you so please to term it, to the physicians of this country. In developing this acquaintanceship, the result that is bound to ensue is an increase of numerical strength that will be an index to apply the four basic principles that have

been advanced. It will be promptly perceived that this acquaintanceship will eventually produce results that more nearly express the ends that are being sought.

To that end, then, do I proffer this program:

First: That as we return to our home states we pledge ourselves to concentrate, so far as possible, in causing the medical men of our state to become fully informed and acquainted with all that medical organization as represented by our county, state and American Medical Association is and stands for and what it is doing.

Second: That this information be continuously distributed and conveyed to the informed and uninformed by means of:

A. Special articles, editorials, comments and advertisements appearing in each issue of our state publication.

B. That county secretaries be requested to act as local representatives for their counties and that they be supplied with application blanks for membership.

C. That, as we send certificates for 1925 state membership we include a plea and application for A. M. A. Fellowship.

D. Through such other avenues as may be determined.

Three: That we solicit Fellowship affiliation. Means and methods will suggest themselves as we become enthusiastic in this program and as we apply ourselves to its institution. One avenue that merits our thoughtful consideration is the county society unit. Have we not been neglecting state interest in our county societies, and is that not the reason why each state organization has a varying number of county societies that are dead or exist in name only? We need a greater acquaintance and a more intimate one with our county societies and their officers. We must manifest more interest in their activities and we greatly need to rejuvenate their spirit of work. In our 1925 program we must not lose sight of the county society, and we may well utilize this avenue for a greater application of our purpose to establish acquaintanceship.

I would also suggest that our national Secretary cause to be compiled a concrete

tabulation of the activities that emanate from national headquarters, including our councils, bureaus, publications, laboratory, directory and full-time executives. That this tabulation be imparted to our state membership in the most effective manner.

My final recommendation is that this conference pledge itself to this program and that we individually sincerely determine that we will go forth and by our zeal and effort cause 1925 to witness our bringing to the graduate doctors of medicine of this country a full degree of information that will firmly establish an acquaintanceship with our medical organizations that will beget an understanding in such full degree as will cause them to enroll as members and thus attain in a greater degree that which we have announced as the objects that govern our federacy.

#### STATEWIDE HEALTH ASSOCIATION\*

C. H. Richardson, Jr., M. D.,  
Macon, Ga.

In the past few years there has been a great deal of discussion as to the cause of Georgia's non-development along industrial lines in keeping with her importance and potentiality.

Various reasons have been assigned, and you have heard discussed at length such causes as "the Boll Weevil," the "Labor Shortage," (due to the migration of our colored population) and the "Movement from the Farms to the City."

All of these are no doubt pertinent factors, but some of us who have investigated this question from another angle, have come to the conclusion that Georgia's unsatisfactory health record in the Census Bureau at Washington is perhaps the greatest cause of all our unsatisfactory progress.

Investigation along this line furnishes some rather startling facts. We find that the Census Bureau rates Georgia's labor as 65 per cent inefficient, on account of the widespread prevalence of preventable diseases, namely, Malaria, Hookworm, Tuberculosis, Typhoid and Dengue.

We find that Georgia has about 235,000 cases of malaria each year; that about 60 per cent of the children in rural schools where surveys have been made, are infected with hookworm; that we furnished one-tenth of all the typhoid deaths in the United States in 1923, when we have only one-fortieth of the population; that our death rate from tuberculosis is abnormally high, and at present we have no adequate means of caring for the victims of this disease; that there are constantly in this State of ours about 250,000 persons so ill as to be unfit for work when it is an attainable thing to reduce this by 40 per cent. The law of averages menaces the average individual in this State with the certainty of ten days of illness a year.

This we must admit is rather an unenviable record, and let us see what we are doing to remedy it, and what our sister States are doing along similar lines. To find out we must apply the money test, for we all know that public health is purchasable and the eradication of preventable disease is simply a matter of dollars and cents.

We find that our sister State of Florida is spending 25 cents per capita on public health, and we also find that Florida is making the most rapid strides along the lines of industrial progress of any Southern State. We find that North Carolina is spending 16 cents, and even South Carolina 13 cents, while Georgia, the former "Empire State of the South," is spending the magnificent sum of 3 cents per capita on all her public health work. Is it any wonder that we are falling behind in the procession of States along lines of industrial progress? It is self-evident that foreign capital seeking fields for industrial investment will not locate in a State where the incident of illness and inefficiency arising from preventable disease is so high.

But the industrial side of this question is not the most important one after all, for a State owes a duty to its citizens to provide for them a healthy environment, and coming generations have a right to be born into

\*Read before the Augusta (1924) meeting of the Medical Association of Georgia.

such a sphere, or ask us the reason why. Our orphan asylums are entirely too full of unfulfilled responsibilities whose parents have died before their time, and more than four infants out of five have a right to live beyond the first year of life. If the agony of bringing them into the world is worth while, then they are worth saving. The way to save them has been discovered—is waiting to be employed. The statisticians of life insurance companies hold that the way to save babies' lives, to save middle-age lives, and in fact all other kinds of lives is to destroy the emergency ideal in medicine, and to build the preventative and constructive ideal.

This is the challenge that confronts us today, and it is the duty of the Medical Association of this State to get together on a program to raise the general standard of health, usefulness and happiness through sanitary and health services to prevent disease. A beginning has already been made and an organization formed, which deserves our hearty co-operation, and whose aims and purpose I wish to tell you of.

The president of our organization realizing the great need of such an organization, called a meeting last October in Savannah of representative business and professional men to discuss this problem. After some discussion they came to the conclusion that Georgia was falling behind her sister States in progress, and that probably the greatest cause was our poor health record at Washington. They were convinced that the improvement of some of our sister States was due largely to better health conditions, and realized that Georgia must get in line.

And so at this meeting was organized the State-Wide Health Association to conduct a campaign of education to arouse the people of this State to the support of the program which it proposes to sponsor.

The method proposed by this Association to bring this about is:

1. A closer understanding between the commercial bodies, the Medical Association of Georgia, and the State, County and City officials.

2. The medical men are to put before the local Chambers of Commerce, Civic Clubs and Community Meetings the facts and figures as to losses sustained through inefficiency and deaths due to preventable diseases, then have these various organizations to fully co-operate, and have the Ellis Health Law adopted for their respective counties.

3. With this mutual understanding and co-operation, the Ellis Health Law can be made a success. Then have the co-operating bodies convert their legislators and State senators to the necessity for an appropriation that will make our State Board of Health an efficient and effective organization in carrying on the work of eradication of preventable diseases in Georgia.

4. If this can be done in the majority of counties in Georgia, the State will then be in position to cover the appropriation made by each county for better health conditions.

The International Health Board, and the United States Public Health Service will also contribute in money and personnel as they are now doing in other states, and it is estimated that under this method each county will receive \$3.00 for each dollar appropriated.

This is the program which the State-Wide Health Association offers and we ask for your endorsement and co-operation and enthusiastic interest.

This is the campaign that the people of our State are in need of, and it is to us that they must look for intelligent leadership.

If we seize the opportunity and go forward with a real constructive ideal of service to our State, the Medical Profession of Georgia will be restored to the position of confidence and respect which it so richly deserves.

---

#### Discussion on Paper of Dr. C. H. Richardson, Jr.

DR. J. W. SIMMONS, Brunswick: I am so interested in this matter that the other day when Governor Walker sent me his pre-election postal I took him at his word and



immediately sat down and wrote him three type-written pages, telling him my ideas of how he could best emancipate Georgia from her present condition. The theme of that letter was based upon my viewpoint of what Georgia needs in the health program. I told him if he would pay a little more attention in his State House to the health of Georgia and Georgia's children and just a wee mite less to the health of Georgia's poultry, cattle, sheep, hogs and cotton, that I thought he would go a long way toward creating a condition such as he so beautifully described and so ardently wished for in making an industrial mecca for those who are seeking locations in the South.

We are building in Georgia magnificent roadways, but what good does it do a man if he can ride smoothly in his car but still be shaken by chills? What good does it do if he can speed up and yet be slowed down by his hook-worm?

My idea is to get up a program and circulate the legislature with this program, see our representatives personally, and put it over. We can do nothing with glittering generalities. The papers of Dr. Daniel, our President, and Dr. Richardson were fine, but they do not contain the program we will have to outline. The time is short. The Legislature will listen if we have something definite to offer. I have been talking with Mr. Mann and he will be glad to sponsor any legislation we want but he wants to know how we are to go about doing it. We have not suggested any definite legislation. We have laws on our books now,—the Ellis Health Law for instance,—which, if put into effect as they have been in my county, would to a certain extent bring to pass many of the things that we now want. We have the co-operation of the Parent-Teachers' Association and other civic bodies, and I am asking now that the doctors of this state be less selfish in their public service. That they make public service a habit. Everyone will look up to the doctors, will tell him more than the preacher. The doc-

tor carries the destiny of this state in his hands, if he but realized it. Therefore, it is not presumptive on our part to appear before every civic body in our counties and our towns and ask that we be allowed to tell them what we need.

The speaker has just said that the foundation of everything lies in health, and the doctors know more about that than anyone else. The Health Association of Georgia should put on the basis of dollars and cents as a necessity of the business man, the argument as to how we can hope to change the present conditions in Georgia, and gain their interest. They are willing to help us but we have to have a definite program to present to those men in Atlanta. I thank you.

DR. THEODORE TOEPEL, Atlanta: Just a few words in regard to this important paper which was presented by Dr. Richardson. When they founded the State-wide Health Association in Savannah I made the trip down from Atlanta in order to be present at the christening of the baby. I wish to say, as Chairman of the Committee on Public Health and Instruction, that we welcome officially any organization that is interested in public health work. The more the merrier, but there is one point that we must guard against and that is overlapping. This was brought out before. Let these different organizations co-operate and work together as a unit. Legislative representatives are impressed by numbers. A committee representing only one organization goes up and attempts to put over a measure and they do not succeed. If ten representatives should come there and say they represent ten times ten thousand people of Georgia they will sit up and take notice. It is only by the united effort of these many bodies now interested in health, led by the Medical Association of Georgia, that we will ever get anywhere. I certainly endorse this movement most heartily.

## PROGRAM OF THE STATE BOARD OF HEALTH\*

J. P. Bowdoin, M. D.,  
Adairsville, Ga.

Dr. Thos. F. Abererombie, Commissioner of Health, is now at The Hague, sent there by the Surgeon General as a representative from our national government to attend an international convention on prevention of disease. I am sure that each of us appreciates this honor and accepts this as a valid excuse for non-attendance on our annual meeting.

In his absence permit me to say that the appointment of Dr. Abererombie by our national officials only reflects the high opinion held by our various state organizations, and in itself assures us in a most satisfactory way that Georgia has one of the best health organizations in our nation.

I have been requested to say something of our wants and our desires; that we wish to do more than we are doing, and especially to know from discussion what you wish done by your State Board of Health. It is your Board, run and maintained for your use, your service, and through you the entire population of our great State. The need of good, efficient and prompt service to you has never been more urgent. How well we are rendering it is for you to say. We invite constructive criticism; we need it. We ask it most earnestly, but in offering it please bear in mind that the entire appropriation is only \$91,421. I often wonder how we accomplish the amount of work that we do with the small outlay; it would be impossible if it were not for outside aid.

Our State has never qualified under the law for the appropriation made for aid to States under what is known as the Sheperd-Towner Bill for Maternity and Infant Hygiene. This law makes possible the securing of dollar for dollar of federal funds for work among expectant mothers and children under seven years. It really is the most fundamental of all work, as it reaches the vital spot in prevention of death,

and therefore the lengthening of the span of life. The defects found in school children could and should be detected and corrected. The awful slaughter of innocents could be stopped, and many hundreds of mothers who die in childbirth could be saved. Georgia should by act of law qualify for this money. Your aid is requested, not only requested, but earnestly solicited. The time is short.

All who know anything about health work know that programs must be worked out months ahead, as for instance, the eradication of malaria. You cannot do such work in a few months, but it will require years. Any well rounded work in any line must include follow-up and constant personal supervision. Under the present plan of securing appropriations for health work it requires almost constant begging, pleading, praying and imploring of our law makers for money year after year, working from hand to mouth, not knowing this year what we will have the next. It is unsatisfactory, wasteful, making necessary the repeating of work and loss of work already accomplished. It is wasting the public funds in the sense that we cannot get the most for our money. We propose a constitutional amendment removing the health work from the mire and slough of uncertainty and placing it on the high ground of certainty and achievement. We expect to ask the coming Legislature to fix the appropriation for the State Board of Health on a per capita basis on the estimated population as promulgated by our Census Bureau, beginning in 1925 at 4 cents, increasing 2 cents per capita each succeeding year until a total of 12 cents is reached. This will give us the same as North Carolina and half as much as Florida.

We realize that to do this means a hard fight. If we can by your help secure this law we will have taken the most advanced step of any State in the Union; this will enable your State Board to plan its work years ahead and be in position to subsidize the county work in the smaller counties in the State, also to enlarge its facilities for

\*Read before the Augusta (1924) meeting of the Medical Association of Georgia.



aiding you in the diagnosis and treatment of disease. Come, let's go.

The Congress now in session has passed its appropriation bill, and as we expected, has cut the venereal disease money. Georgia will get \$684.85. Compare this with the \$32,000 given us in 1918. The State has not increased its appropriation; on the other hand, cut it \$5,000. This means the discontinuance of free Keidel tubes and Arsphenamine within the next few weeks. What are we to do? Last year we furnished to the doctors of our State 21,538 Keidel tubes and 19,596 doses of Arsphenamine and its various modifications. What can we do? I am now considering offering you Keidel tubes at cost, and will endeavor to make a contract for Arsphenamine at the government rate and supply you at cost, sent only C. O. D. Can you suggest a better plan?

It is indeed gratifying to note by a comparative study of the monthly and annual reports the rapidly growing confidence of the physicians in the service being rendered by the Laboratory. An increase from less than 6,000 specimens in 1918 to 40,000 in 1923 is sufficient witness to this statement. Unfortunately, however, the increase in the laboratory services necessitates a corresponding increase in the operative budget; the present equipment and personnel are loaded to capacity limit. Not only is expansion along new lines of development imperative, but actual curtailment is impending unless additional funds are available.

Last summer we did our best to get enough extra money from our law makers to enable us to furnish you Toxin-Antitoxin free and install in our Laboratory a department for urinalysis and examination of tissues for malignancy. We failed, although the amount needed was small. We still hope to do the work for you; do you desire it? If so, put your shoulder to the wheel. We also have in mind supplying Tetanus Serum; it is needed and should be given you.

Something must be done with our dogs; it is one of the serious problems in Georgia. We made and distributed last year 2331

treatments for rabies. We examined 857 animal brains. What is the best solution of the problem; a solution that is practicable, workable? Would a tax on dogs, payable to the Board of Health, devoted to this work and the prevention of animal rabies do the trick? We want your help.

As you know, the last Legislature did a great piece of work for Tuberculosis, the tobacco tax, the first \$500,000 of which is to be used to build a new sanatorium for white patients at Alto. This bill was fought and fought awfully hard, it passed by one vote, and that of the President of the Senate. It is now held up in the courts; it has been argued before the Supreme Court and decision should have been handed down April 10th, but has not come out as yet. It will be sustained, in my opinion, but possibly the delay means a dissenting opinion. When this building becomes a reality we will take care of 212 whites and 100 negroes. As you know, the negro has never had any care or attention; much of our infection is spread through this source. If we get the new institution it will be thoroughly equipped with X-ray and full laboratory equipment.

If we could secure a small additional appropriation we could increase our present number of inmates in the institution that we now have. Last year Dr. Glidden had patients from 92 of our counties. In 1919 we handled 200 patients; in 1923, 360. Early cases are the ones that we are supposed to treat, yet we had only 5 incipient cases, moderately advanced 125, so out of the total we only had 130 that offered much opportunity. Moral: watch closely all patients you have; make thorough examination of every patient, that you may detect the incipient case; too many slip by and become hopeless.

Owing to the usual cry of hard times we have not put on many full time health officers, but all must realize that this is the only way to do effective health work. We hope with more money to give State aid to the weaker counties. We have a good



law and only need to put it into service. A full time health officer in your county can be of great value to you.

The Division of Sanitary Engineering has been growing and developing. In 1910 the Laboratory made 555 examinations of water, in 1923 over 5,000. The malaria work has increased over 700 per cent. It is impossible with the present personnel to give personal supervision to water supplies and malarial surveys. It is useless for me to say that we wish to do so, but with the money in hand we cannot. The filtration of water supplies for our towns and cities needs our attention badly; we are doing all we can, but it is far short of our desire and demands. We do hope that the day is not far distant when any citizen of our State can obtain an analysis of his private water supply free; now a charge must be made for it. Too much emphasis cannot be placed on good work on water supply, sanitation of homes and communities and malaria control.

I fear that the busy physician does not realize the importance of reporting his infectious and contagious diseases; I am forced to this conclusion because they are not reported. I do not believe it is meanness and contrariness on your part; I believe that down in your hearts you wish to obey the law and aid your community, state and nation; it is not perverseness, but negligence. We beg of you to report your diseases that are reportable, and the Vital Statistics Department must have the birth registration if we are to be admitted to the registration area. This Department was organized in 1919. We have been admitted to the registration area for deaths, having secured 90 per cent of them.

In 1922 we appealed to you to aid us in being admitted to the registration area, but on the test we failed by 5 per cent. We appeal to you now, today, to see that all births are promptly reported, and to give to this important matter your influence in seeing that all midwives send in the reports that they should. This is very important, perhaps more so than you would think. With the death records complete and the

birth records short our infant mortality rate is worth but little, for the reason that it does not represent the actual conditions. The State Board of Health must and does depend on the ethical physicians to assist in this very important matter. I am quite sure that if you know the necessity you will respond to the call for service.

The last Assembly passed a bill removing two physicians from the State Board of Health and placing thereon two dentists. We have no objection in the world to the dentists; we are indeed glad to have their aid, advice and sound counsel, but we did dislike to lose permanently medical representation from the 9th and 11th Districts. We did our best to have the physicians retained. We hope that the coming Assembly will change this law, add the dentists from the State at large and let us retain the original Board; we think it should and will be done. The State Board of Health should be controlled by the physicians of the State.

The Marriage Bill was introduced, passed the Senate by a big majority and is now unfinished business in the House. It is legislation along the right line—not an ideal bill, but the best that can be put on the statutes of our State at present.

The feeble-minded of our State are a great problem. The present institution, presided over by Dr. G. H. Preston, is located near here at Gracewood; you are invited to ride out and see it. The institution is so small that the percentage that can be taken care of is limited. We have a long waiting list; many of the cases are urgent. Valuable time is being lost, owing to the want of an appropriation to take care of them. Good work is being done with the children there; something should be done to arouse our people to the need of the institution; it is important—imperative.

There is a baby born in Georgia every 7 minutes. Before another sun sets 11 of them have died; 4,366 died last year under one year of age; 3,157 were stillborn; 637 mothers gave up their lives in the supreme sacrifice of childbed. Of the 69,615 babies born 22,709 of them had no physician in

attendance. Practically one-third of all our mothers were attended by midwives, perhaps all of them, surgically speaking, dirty, filthy. Here, my fellow physicians, is one of the most serious problems of our State; here is a responsibility and opportunity for service; here we find a field that must have attention. In this problem we have an opportunity for good work, life-saving work; here we have a responsibility to our fellow man and to our State and Nation. I mention it here and now to ask this Association to take definite, decisive steps to better the situation. I ask that this Association take the matter up and pass upon it. The midwife is here; she is here to remain. What is best to do with her, and how?

We have our views; we now ask you for yours, and that you outline to us your proposed program for this very serious situation. What does the medical profession wish the State Board of Health to do? For the sake of expectant mothers and unborn babies of our State, tell us in your wisdom the best thing to do for them. The problem to one with a quickened conscience and a feeling of responsibility is one of great concern; it worries me; it distresses me. Let this cry from these women and babies sink indelibly into your hearts and brains; do something; do it quick!

#### **Discussion on Paper of Dr. J. P. Bowdoin**

DR. JOSEPH YAMPOLSKY, Atlanta: For several months I have been in intimate contact with Dr. Bowdoin in his work. Because of my work in syphilis in children in Georgia I have come in contact with him and have called upon him for medicine for free distribution. When we can consider that in a city the size of Atlanta 10 to 12 per cent of the colored population is born syphilitic, and that perhaps 6 or 8 per cent of the whites are born syphilitic, we can realize what it will mean to have arsphenamin taken away from us. Probably 90 per cent of all the syphilitic children would die if it were not for the fact that they are treated properly. I believe that between 8 to 10 per cent of all the children born

in Georgia are syphilitic, and yet we are allowed only six hundred and some odd dollars for arsphenamin. Toxin-antitoxin has been distributed at a small cost and diphtheria antitoxin has been given free. There is no use to read papers year after year. Nothing comes of it. We need concerted action and we must combine with all the social agencies there are in Georgia and demand something as a body and it will be given to us. If we should find something that would cure cattle and hogs, no difficulty would be encountered in getting legislation. These same legislators will take out insurance on their lives but are not willing to insure the health of the coming generation. We must not be behind. We must act, but not as listeners and go away. We must combine with all the Parent-Teachers Associations and all the others that are interested in this work and then we can act. If you saw the class of quacks and doctors that advise some of these Parent-Teachers Associations you would be ashamed, but it is not the fault of those workers because they do not know who is right and who is wrong. We should offer our services and then we can expect something in return.

DR. C. H. RICHARDSON, JR., Macon: As a member of the State Board of Health I wish to endorse very heartily everything Dr. Bowdoin has said. Our appropriation has been out this year, the Government appropriation has been withdrawn, and unless we can get some help we will suffer materially. What can you do to help us out? You can show that interest that will give us some influence when we go before the legislature. When the Agricultural Association goes up it has representatives from all over the state and they get \$500,000.00. We go up with one or two doctors and they will not even listen to us. If you will each go home and talk this before any and all of your civic clubs, stressing the importance of this matter, and get them to pass resolutions and let these be sent on to the legislators with your commendation, they will be impressed with the fact that the people of Georgia are really interested in public

health work. If you will do that and get some influence before the legislature meets in June, I think we will be able to get some help.

MRS. C. A. VerNOOY, President, State Kindergarten Association, Athens: I wonder if your Committee would not give us a letter and let us send it to all of our organizations throughout the state, and have them forward it to their various representatives. We want to reach them all with an educational and legislative program before they reach Atlanta.

DR. FRANK K. BOLAND, Atlanta: Before we go to the Legislature with these matters we should see that we have a sympathetic Legislature. It is our duty to put men in office who are in favor of public health. We should not support men who are not interested in public health work. If we do not do that we cannot expect to get a sympathetic hearing when we go before our Legislature. It is the duty of every one of us as public-spirited citizens to register and vote.

### **TIPS FOR THE COCK-SURE SPECIALIST\***

**Elton S. Osborne, M. D.,  
Savannah, Ga.**

This is the age of specializing. The patient is divided into numerous parts, each part is limited and circumscribed with meticulous care, over each is a specialist as the presiding deity. This arrangement is awe inspiring.

The chief concern of the patient is the effectiveness of treatment. How much more efficient is the treatment of disease today, than in the day of the primitive medicine man, who performed the complicated hocus-pocus that cured all ills and averted calamity? It is true that preventive medicine has made great strides; the population is no longer perennially decimated by the catastrophe of epidemic disease; we know the cause of far more diseases than did the

ancients. How much does the discovery of the cause benefit the treatment of disease?

Koch made an epochal discovery when he discovered the cause of tuberculosis. It was inferred that as the cause was discovered, the cure would be easy and soon a tubercular vaccine was heralded as a cure, this created a furore, marvelous cures by tuberculin were announced. Ten thousand failures were overshadowed by one brilliant success. There was a pilgrimage of tubercular patients to Berlin to receive the treatment first-hand. Results were disastrous. Virchow sounded a note of warning that tuberculin was waking up even latent tubercular processes and causing a mobilization of tubercular germs. For a decade the medical profession concurred in the advice of Nicholas Senn, "Away with tuberculin."

Tuberculin was revived by Wright, using his Opsonic Index to control dosage, today the Opsonic Index is in the discard but tuberculin is still used though in doses a thousand times smaller than originally recommended by Koch.

The accepted remedies of any generation are ridiculous to the second succeeding generation. Our children's children will scorn the remedies that cure our ills. The sure-cure of today is the laughing-stock of tomorrow. We ridicule the old shot-gun mixture of drugs of yesterday but the shot-gun vaccine of today is much more ridiculous and a far greater menace to public health. Although it has never been proved that any vaccine has value in preventing or curing "Colds," this vaccine is one of the most popular. From time to time the various manufacturers of "Cold" vaccine have added new strains of bacteria to their original formula so that now seventy-five or eighty different types of bacteria are included. Suppose—although it has never been proved—that one of the varieties should be effective. What becomes of the other Seventy-five? Why are only seventy-five or eighty varieties of bacteria included? Why not include all the multitudinous hosts?

Our aesthetic sense revolts at the idea of

\*Read before the Augusta (1924) meeting of the Medical Association of Georgia.



the medieval physician testing a patient's urine but we have no compunction about feeding our patients *Bacillus Acidophilus* obtained from the dung of infants.

"At every time in the earth's history when men have had much chance to think about themselves rather than the actual necessities of the situation in which they were placed, and the things they were compelled to do for actual self-preservation, specialism has enjoyed a period of more or less intense evolution. Among the ancient Egyptians physie was so studied and practiced that every disease bath his several physicians, who striveth to excel in healing that one disease and not to be an expert in curing many. Whereof it cometh that every corner of that country is full of physicians. Some for the eyes, others for the head, many for the teeth, not a few for the stomach and inwards." An intense specialization. How different was the practice of the Greeks, the only true physicians of antiquity.

"Greece, where only man whose manhood was as Godhead ever trod."

"Bears the blind world witness yet of light wherewith her feet are shod."

Socrates tells us that a clever physician when any one comes to him with a pain in the eyes, will say that they must not attempt to cure the eyes alone but that it is necessary for them at the same time to attend to the head, if the eyes are to be in good state, and, on the other hand, that it would be great stupidity to think of attending to the head alone without the whole body. Even then many diseases escape the physician because just as it is not proper to cure the eyes without the head, nor the head without the body, so neither is it proper to cure the body without the soul. They are thus ignorant of the whole, to which attention ought to be paid. It is impossible for a part to be well, unless the whole is in good state. Talk to a modern specialist about body and soul and he thinks you are "spoofing" him.

The practice of medicine is a noble calling. No set of men gives as unselfish service to their fellow man as the medical pro-

fession; night and day, rain and shine the Doctor plods along giving scant thought to the remuneration, his is always the last bill to be paid. The spectacular specialist is the boy who brings home the bacon, selling his patients the idea that some operation is vital they go out and beg, borrow or steal in order to get the coin.

Surgeon Guy Patin bled his wife twelve times for a fluxion in the chest; his son twenty times for fever; himself seven times for a "Cold" in the head; his friend Mantel, thirty-six times for fever; his friend Cousinot, sixty-four times for rheumatism. We are amazed that he could fool his patients into any such procedure; the patients of a cock-sure spectacular modern specialist is no whit less fooled. Dr. Sangrado, the tall, withered, wan executioner of the sisters three would draw off his few good porringers of blood but today there is many a good porringer of blood drawn under the guise of a tonsil or turbinate operation.

Our distinguished colleague, Doctor Davis, stated that many cases would not be brought to the operating table if examined properly beforehand. Even in our most modern hospitals with all the refinements of diagnosis results have shown that not more than two-thirds are accurately made. Rowland, carefully following over a thousand cases found correct diagnoses made in thirty-eight per cent of cases treated in institutions, but not over twenty-three per cent of cases treated in private practice. Spriggs in a study of five hundred cases concluded that forty per cent were accurately made. Treatment is necessarily based on the diagnosis; if the diagnosis is wrong treatment is certainly at fault.

The public mind gears are now running in high, they infer that as science has furnished machines to accomplish so many and wonderful tasks, that it can furnish a machine to diagnose their ills and administer the proper treatment. Mechanical devices and laboratory methods are looked upon with the reverence of the Gospel and in an attempt to be up-to-date physicians rely on these tests to the exclusion of other meth-

ods. In the presence of an X-ray or laboratory finding all other avenues of thought are put to sleep.

Sir James MacKenzie, the greatest living physician, says that there has never been a single mechanical or laboratory method introduced but has had an extremely limited sphere of usefulness. Time and again great expectations have been raised by the announcement of some wonderful discovery that was going to have a revolutionary effect on clinical medicine, but as time went on its sphere of usefulness was found to be a very limited one.

The X-ray and laboratory are invaluable when their findings corroborate clinical symptoms but the Cock-sure X-ray Specialist, who takes a picture and from this sits down and writes a diagnosis, is a menace to the community. "The more superficial, ignorant or dishonest the man, the more dogmatic and hasty are his diagnoses for with breadth and depth of knowledge comes its highest gift, a conception of its limitations."

One of the dangers that besets specialization is the narrowness of the piece worker. An automobile mechanic claiming to be an all-round man applied for a job, he had years of factory experience, he was asked what were his duties in the factory, he replied, "Screwing on bolt 606 on the Ford machine." Many a modern specialist, with the stage setting of consultation offices, hospitals and dainty, demure, delectable nurses, is busily engaged in screwing on bolt 606 on the human machine, the fact that he sometimes leaves a monkey wrench in the balance of the works does not concern him as his job is to accurately and expeditiously adjust bolt 606.

An inquiring traveler came upon three men engaged in cutting stone, "What are you doing?" he asked of the first. "Cutting stone," answered the man. "What are you doing?" he inquired of the second. "I am earning five dollars a day," the man replied. "And what are you doing?" the third man was asked. "I am building a cathedral," was the answer.

When a specialist becomes narrow with

a loss of adaptability, he is cutting stone. When he is dominated by selfish materialism, he is out solely for the money. The specialist with true scientific ideals lays aside arrogance and selfish opinionatedness and in all humility recognizes himself as but a cog in the machine for the alleviation of suffering of humanity and dedicates himself to render the greatest service possible to his fellow man. He is not cutting stone, he is not out for the money, he is building a cathedral.

### OMENTAL GRAFTS AS A MEANS OF RELIEF AFTER LIBERATING EXTENSIVE ADHESIONS IN ABDOMEN

E. C. Davis, A. B., M. D., F. A. C. S.,  
Atlanta, Ga.

Abdominal adhesions have long been one of the banes of existence following many operations or infections in abdomen without operative relief. So often has this been the case that many patients are led to fear the after results of operations as much as the operation itself. Even with the greatest care and most painstaking precautions these will develop in a certain number of cases. Many of these may be attributable to infections resulting either from the disease necessitating the operation, or some slight break in the technique during the operation, the penetration of a needle into the lumen of the gut, rough handling of the abdominal wall or intestines, injection of irrigating drugs into the abdominal cavity, trauma from dry pads, or other means which would ordinarily be avoided by gentleness and care.

When one stops to think how nature endeavors to protect the intestinal viscera by suspending it in a serous lined cavity with just enough fluid to protect it from irritation or friction, we may readily understand that it must be a tissue of such a nature as to require extraordinary care to protect it from violence and harm. On the other hand when we see how nature often seals over raw surfaces in order to protect the viscera after the harmful forces have been active, how



crude and awkward they sometimes appear, we are impressed with the fact that these may have been made as temporary protections to be later corrected by intelligent direction.

Every surgeon of experience is amazed at times on reopening an abdomen to find some with viscera almost agglutinated to many intra-abdominal surfaces and yet no active obstruction has resulted, and again in other cases to find a few filamentous bands over the intestines, or a slight attachment of omentum to intestines and a complete obstruction resulting with all its attendant disastrous possibilities.

To know just when to operate for relief of adhesions, and often to know just what to do for this relief, is a problem of no small magnitude, and requires judgment based, as a rule, upon a wide experience and a degree of skill in covering over raw surfaces without leaving other surfaces for the reformation, sometimes of a condition worse than that which we attempted to correct. If after liberating adhesions we find it possible to peritonealize the surface completely, we may anticipate much benefit from the procedure, but if we leave raw edges, or have an infection result, the condition is usually aggravated.

When peritonealization proves impossible by sliding or coapting the peritoneal surfaces, if this raw surface be on the intestine it may be wiser to resect the intestine and remove the part so traumatized. If this is not deemed safest, a graft taken from the omentum and carefully adjusted has resulted in great relief in several cases coming under my care. One of these was especially impressed upon me for the reason that a year before I had operated for an acutely inflamed appendix, following this operation much relief resulted for about six months, then the old pain from which he had suffered since childhood returned in the right side, extending from the costal margin to Poupart's ligament. This is described as a drawing pain with much aching, so severe had this become that he was forced to give up for a time his work as a civil engineer, and later spent much of his

time recumbent with his hand pressing firmly the right side. His bowels responded to purgatives, but without them he was inclined to constipation. He was then returned to the sanatorium properly prepared, the abdomen re-opened, making a right rectus incision again over the old site somewhat longer than in the previous operation. On entering the abdomen I found adhesions of omentum to abdomen, a few adhesions around the old appendix site, but on going higher there came under observation an extensive so-called Jackson's veil, extending for several inches over the ascending colon and the cecum, even down upon the meso-coecum. This was carefully dissected off, leaving a raw surface about 2 inches transversely or three inches in length. As to how to protect this was a problem. It could not be peritonealized without angling the intestine too much and running risk of an obstruction, so I then ligated a portion of the omentum just large enough to cover this accurately, and cut it off, adjusting it to the raw surface. It coaptated itself accurately and fitted like a wet piece of tissue paper when applied to a surface. This was then stitched with 00 chromic catgut, interrupted stitches, requiring eight or more. The incision was closed without drainage, and recovery was uneventful except for a small stitch abscess.

Now about two months have elapsed, and the patient reports complete relief from all pain and discomfort, something which he has not known since childhood.

Omentum grafts have been used for a long time, the first time by me was about twelve years ago, and appears to be distinctly successful. I have never had the misfortune to examine them post mortem, so cannot say how demonstrably they have proven a success, but can repeat symptomatically they have resulted in relief from symptoms.

In "Surgical Clinics of North America,"\* Frank C. Mann, of Mayo Clinic, gives his experience with transplantation of fat in peritoneal cavity with the following conclusions:

"1. Our experiments seem to indicate that the free omental transplant has a very



limited application in surgery of the peritoneal cavity. The greatest benefit from its use seems to be in stopping hemorrhage from a parenchymal organ. In this respect it seems fully as good as the attached omental transplant.

"2. A free transplant of omentum in the peritoneal cavity may remain seemingly viable for as long as one year, and retain some, although only a small percentage of its fat. In many instances, however, after a few weeks the transplant is reduced to an almost fat-free scar-like tissue.

"3. By exercising great care it is possible to use a free omental transplant to prevent adhesions, but the value of such a procedure is greatly decreased by the fact that unless infinite care is exercised the results, in all probability, will be worse than if the transplant had not been used.

"4. A free transplant of omentum is not safe for routine use in patching an opening of the gastro-intestinal tract.

"5. While a free transplant of omentum may be of some value in reinforcing the suture line of a gastro-intestinal anastomosis, it does not compensate for the careful use of the regular method of suture, and probably is of no advantage.

"6. A free transplant of omentum can be used partially to replace lost peritoneum, but the transplant is not so good as suture, and unless great care is exercised the results may be worse than if the area had been left denuded.

"7. The gastro-intestinal canal can be occluded partially by a free transplant of omentum.

"8. A free transplant of omentum packed into a wound of the liver, spleen, or kidney stops hemorrhage from the wound.

"9. There is a wide range of possibilities for the use of the intact omentum in the peritoneal cavity, providing care is exercised that such use does not furnish a basis for future intestinal obstruction.

"10. An attached transplant of omentum can be used to prevent adhesions, to patch an opening in some part of the gastro-intestinal tract, to strengthen a suture line of the gastro-intestinal tract, to replace lost

peritoneum, to occlude a portion of the gastro-intestinal tract, and to stop hemorrhage of a parenchymal organ. Of course, it is understood that the use of such an attached transplant of omentum carries with it the potentiality of producing intestinal obstruction.

"11. All the statements made concerning the use of the free transplant of omentum are equally true with regard to subcutaneous fat."

From the experiments above noted my cases have not had sufficient time to prove their real value, and I've not had opportunity to use it sufficiently often to prove its real value. Sufficient time and a large number of cases will be necessary to establish the value of such extensive grafts, but it is difficult to understand why with conditions so favorable for successful grafts, that failure would result. An accurately coapting tissue, a clean field, proper temperature and good prospect for nutritional sustenance, protection from trauma and violence, all would conduce to a reasonable hope of success.

\*Surgical Clinics of North America—Sanders & Co.

### A CASE OF HEART-BLOCK WITH RECOVERY\*

George Bachmann, M. S., M. D., and  
Walter W. Daniel, A. B., M. D.  
Emory University, Ga.

A systematic examination of the heart in the bradycardias and arrhythmias with the aid of the polygraph or the electrocardiograph has shown that heart-block of various grades is by no means uncommon as a sequel of the acute infectious diseases. (Peabody (1), Neuhof (2), Wilson and Robinson (3), and Calvin Smith (4). With proper care these cases recover spontaneously. Such cases are evidently due to an inflammatory condition of the bundle of His such as affects the general myocardium. Occasionally, a patient fails to recover spontaneously; the heart-block persists after convalescence is otherwise complete. The case which is the object of this report falls within the latter group.

\*From the T. T. Fishburne Laboratories of Physiology, Emory University, Atlanta, Ga.

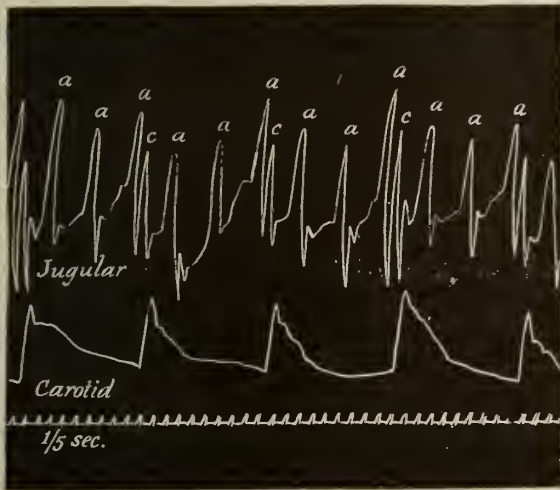


Fig. 1. Polygraphic tracing of the heart's action on June 6, 1922. The tracing shows three auricular contractions to each ventricular contraction (3:1 rhythm).

### History of the Case

Dr. B., a general practitioner, age 50 years, white American, married, came for examination June 6, 1922. His past history is negative. He has never had any severe illnesses, except diseases common to childhood. He has not had scarlet fever, diphtheria, rheumatic fever or typhoid fever. He has been engaged in the practice of medicine for 20 years, doing a great deal of riding in the country, and being exposed to all kinds of weather. In the winter of 1918-19, during the influenza epidemic, he had to do very heavy work in the most severe winter weather, covering often 90 to 100 miles daily and working often 18 to 20 hours a day. He himself fell, at this time, a victim to the disease. His attack was of moderate severity. Aside from marked asthenia, he experienced no particular inconvenience.

His family history shows little of interest. His father died at the age of 60 of nephritis and his mother at the age of 75 of the same malady. There is no history of tuberculosis, cancer, insanity or diseases of a hereditary nature in his family.

His habits are good. He has used alcohol moderately and at irregular intervals only.

### Present Illness

In June, 1921, he began to notice shortness of breath. His pulse was infrequent, being found on examination, to be only 36

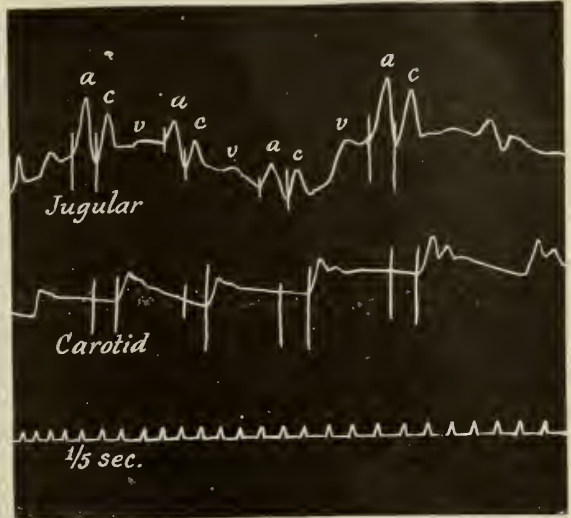


Fig. 2. Polygraphic tracing in June, 1924. The tracing shows a normal mechanism of the heart's action, immediately after a climb of two flights of stairs.

per minute. He went to a private sanitarium for observation and diagnosis, remaining there for ten days. At this time his blood pressure was 130/80. The urine was negative and normal in amount. Blood examination showed a slight anemia. His left last molar tooth was slightly loose and was removed because of a possible focal infection. Ten days after the removal of the tooth, the pulse rate returned to 72 per minute. The patient was greatly improved and began taking more exercise, playing golf and taking up his work in practice. He gained in weight until September, 1921, when the shortness of breath returned and the pulse rate again became slow (36 per minute).

### Findings

At the time of the examination made by us (June 6, 1922) the pulse was 36 per minute. Following a period of rest the pulse rate rises to as high as 60, and the patient feels considerably better. Upon exertion the pulse rate falls again to 36 and, at times, as low as 30 per minute. There is no history of syphilitic infection and the blood Wassermann and provocative Wassermann are negative.

Polygraphic tracings were made which showed an incomplete heart-block of high grade. (3:1 rhythm). (Fig. 1). As heart-block may be caused by irritation of the vagus nerve—particularly of the left vagus



—the atropine test was used to rule out this possibility. This test consists of the administration of 1/50 grain of atropine sulphate hypodermically. Tracings of the heart's action are taken every five minutes until the action of atropine no longer manifests itself. This test was negative, the dissociation between the auricles and ventricles persisting throughout. The heart-block in this case was evidently due to some actual interference with the transmission of impulses over the auriculo-ventricular bundle. The damage to the bundle was probably inflammatory in origin. Thayer and Peabody (5) who reported a case of intermittent heart-block quote Hay's case in which there were also periods of block separated by normal intervals; the autopsy showed a partial destruction of the bundle in a patch of fibrous myocarditis.

The patient was advised to take more rest and was given iodine medication in the form of syrup of hydriodic acid. Under this simple form of treatment he gradually increased in strength and fatigued less readily.

Two years later he reported for another examination. A tracing taken at that time shows a normal heart's action. (Fig. 2.) The patient states, however, that following exertion, or when unduly fatigued, the bradycardia returns. It is not, however, of as severe a grade as formerly, the pulse rate never falling below 60 per minute. The damage to the bundle is apparently permanent although a sufficient number of healthy fibers remain to convey the excitatory impulses from the auricle to the ventricles under ordinary conditions of cardiac activity. If the frequency of the auricular beat increases, the damaged bundle is unable to carry the impulses as fast as they originate in the sino-auricular node and the heart-block returns, although it is of lesser grade being probably incomplete in nature. Similarly, general bodily fatigue will affect the heart's action. As the products of fatigue influence the heart tissue in common with other tissues, the fibers of the bundle decline in irritability and are then unable to conduct all impulses to the ventricles, an

incomplete heart-block resulting.

In view of the fact that cases of heart-block of inflammatory origin occur in which intervals of normal heart's action are seen, it is pertinent to inquire whether the iodine medication prescribed in this case was in any way responsible for the recovery of the patient. The manner in which iodines act is still a disputed question, although pharmacologists state that iodine is taken up by necrotic tissues to a greater extent than by normal tissues. Joblin and Petersen (6) have established also that iodine combines with the antitrypsin found in the blood and the necrotic material. The tryptic ferments are thereby permitted to digest the necrotic tissue which is then absorbed, while contained bacteria are set free. Whatever the action of iodine, it would seem worth while giving it a trial in those cases of heart-block of inflammatory origin that fail to clear up within a reasonable time of the acute condition responsible for the affection. At this writing, the patient has had no return of constant heart-block, eighteen months after its disappearance.

The success of iodine medication in heart-block must in a great measure be dependent on the duration of the condition. When the pathological process has advanced to complete organization of the inflammatory area, iodine is of doubtful value. Generally, the heart-block then becomes permanent and it is at this time that in the usual case those epileptiform or apoplectic seizures make their appearance. These seizures are due to a sudden cessation of ventricular activity owing to an inability on the part of the ventricles to develop their inherent rhythm. Meanwhile, the auricles continue their contraction and force blood into the distending ventricles. As there is danger that the distended ventricles may fail to contract again, it is necessary to tide the patient over the period during which the dormant rhythmicity of the ventricles is awakened. As shown by one of us (7, 8, 9), this is best accomplished by the administration of sufficient doses of strophanthus to increase the irritability of the ventricular muscle or of that



portion of the auriculo-ventricular bundle in anatomical relation to the ventricles.

#### BIBLIOGRAPHY

- (1) Peabody, F. W.—Arch. Int. Med. 1910, V 252-262.
- (2) Neuhof, Sellan—Jour. A. M. A., 1914, LXIII, 577-579.
- (3) Wilson, F. N., and Robinson, G. Canby—Arch. Int. Med., 1918, XXI, 181.
- (4) Smith, S. Calvin—Jour. A. M. A., 1921, LXXVII, 765-771.
- (5) Thayer, W. S., and Peabody, F. W.—Arch. Int. Med., 1911, VII, 3.
- (6) Joblin and Peterson, quoted by Bastedo in "Materia Medica, Pharmacology and Therapeutics," 1918, 2nd Ed., W. B. Saunders Co., Phila.
- (7) Bachmann, G.—Amer. Jour. Med. Sc., 1909, CXXXVII, 342-364.
- (8) Bachmann, G.—Arch. Int. Med., 1909, IV, 238-252.
- (9) Bachmann, G.—Jour. Exp. Med., 1912, XVI, 25-53.

### THE DIAGNOSIS AND TREATMENT OF NON-SEASONAL HAY FEVER\*

Hal M. Davison, A. B., Phar. B., M. D.,  
Atlanta, Ga.

The group of symptoms called "hay fever" was first described in 1819 by John Bostock, an Englishman. The designation of hay fever was given to the disease because its symptoms occurred during the haying season. Eighteen years later, Elliotson, also an Englishman, first attributed the attacks of hay fever to the pollens instead of hay. (1) In 1873, Blackley of London, himself a sufferer from this disease, offered the first proof of the relation between hay fever and pollens, while (2) Dunbar gave the final and conclusive proof of this fact in 1903. Three years later, (3) Wolff-Eisner suggested that hay fever was an immunological phenomenon, experiments soon proved this, and in 1911 (4) Noon and (5) Freeman reported the first cases of seasonal hay fever successfully treated by the use of pollen extracts.

With the development of the immunological treatment of hay fever, there came more scientific nomenclature for diseases of this kind and, following the classification of (6) Doerr, hay fever was called allergic coryza. Because of a controversy concerning the application of the word allergy, (7)

Cooke and Coca coined the word atopy to refer to the group of inherited immunological diseases,—including asthma, hay fever, urticaria, and angioneurotic edema,—and hay fever became known as atopic coryza. The symptoms of allergic, or atopic coryza are too well known to require enumeration.

Although it had been noted that cases simulating this disease occurred throughout the year, either continuously or spasmodically, no connection was made between the seasonal type of symptoms known to be caused by the pollens and the non-seasonal type of unknown origin. The treatment of the last mentioned type had been unsatisfactory.

Following the theory of Wolff-Eisner advanced in 1903, that hay fever was an immunological manifestation, (8) Meltzer, in 1910, suggested the same relation for asthma. After means of successfully diagnosing and treating hay fever had been developed, it was only a short time before the same methods were applied to the diagnosis and treatment of asthma. This necessitated the preparation of protein extracts, now called allergens or atopens, from a large number of substances, including all foods, all fluffs and powders with which humans came in contact, and with all animal and fowl emanations.

In many asthmatics, attacks are either preceded or accompanied by sneezing and other symptoms of hay fever. In other cases, spasmodic but violent attacks of hay fever and asthma alternate, and in still other instances, a continuous hay fever occurring throughout all seasons, is occasionally interrupted by an attack of asthma. Practically all of the above three types of asthma associated with symptoms of hay fever prove to be sensitive to one or more of the inhalants,—that is, the dusts, powders, and emanations. Due to this fact it was supposed that the continuous, non-seasonal types of hay fever were also caused by the inhalant group of atopens, which has proven to be true in most instances.

Medical literature for the past twelve

\*Read before the Augusta (1924) meeting of the Medical Association of Georgia.

years has been filled with reports on the diagnosis and treatment of hay fever, but there is relatively little material concerning the non-seasonal types of this disease. (9) Hansel of the Mayo Clinic reports one hundred cases of vasomotor rhinitis, only thirty-one per cent of which gave positive reactions to the protein extracts. Both the seasonal and non-seasonal forms are included in the report. Hansel found eleven cases sensitive to foods alone, six sensitive to both foods and to bacteria, two sensitive to animal emanations alone, one to both animal emanations and to bacteria, eight to bacteria only, one to pollens and to bacteria, eight to pollens alone, one to foods and to animal emanations, and one to pollens and to animal emanations. (10) Novak and Hollender report a series of thirty-nine cases cured by the administration of calcium lactate and extract of thyroid together with irradiation by the air-cooled ultraviolet light. Following the study of the basal metabolic rate in hyperesthetic rhinitis and asthma, (11) Simpson found some few cases with a low metabolic rate that were relieved by the administration of thyroid extract. (12) Selfridge, in discussing vasomotor disturbances as a whole, asserts that evidence is slowly accumulating to prove that the ductless glands play a part in these disturbances. (13) Bareat reports a small series of cases of vasomotor rhinitis successfully treated by doses of the Roentgen-ray applied to the conjunctivae and nose. The French immunologists, led by (14) Valéry-Radot, advocate the treatment of all immunological diseases by the administration of peptone one hour before meals and have found this treatment efficacious for nasal hydrorrhoea. A mixture of fish and meat peptones or some impure commercial peptone seems to give the best results. (15) Krogh of Copenhagen has successfully treated three cases of vasomotor rhinitis by this method. Walker lays stress on the repair of nasal defects and advocates the use of vaccines. He had formerly reported twenty cases of hay fever due to emanations of the horse, seven caused by foods, two caused

by chicken feathers, and twenty due to bacteria.

The above reports give a fair idea of the medical literature on the subject of non-seasonal hay fever, also known as vaso-motor rhinitis, and hyperesthetic rhinitis, but properly called non-seasonal atopic coryza. We will now give a few short case reports illustrating the diagnosis and treatment of this disease from the immunological standpoint. All the cases reported, except case four who was referred by her local physician, have been referred by eye, ear, nose, and throat specialists who had already given such local treatments, operative and otherwise, on the nose and throat as they deemed necessary. The methods used in testing have already been fully described before this society. The protein extracts used in testing were the liquid atopens prepared in our own laboratory according to the methods of Cooke and Coca. The powdered extracts of Squibb and Arlington Company have been used as a check and for the sake of thoroughness. Each case was tested with all the inhalants, with the foods, and with the bacteria.

Case 1. M. H., a white female, aged 22, complained of colds off and on for about a year with repeated attacks of sneezing increased by dusts or powders of any kind. Sneezing was followed by redness of the eyes and profuse lachrymation. Her father had suffered from nose colds and one sister had eczema. Skin tests gave a positive reaction to orris root only.

Case 2. I. G., a white female, aged 17, was referred with the diagnosis of hyperesthetic rhinitis of one year's duration. She complained of inability to breathe through the nose, five to six attacks of sneezing every day, and partial loss of the senses of smell and taste. Attacks were increased by some face powders, and by contact with wheat flour. She had suffered with urticaria at the age of eleven and with periodic gastro-intestinal upsets during her entire childhood. Positive reactions were obtained to orris root, rice, and wheat from the inhalant group, and to almond, aspara-



gus, cauliflower, coffee, eggplant, fig, pear, radish, stringbean, tomato, turnip, and walnut from the foods.

Case 3. R. B., a white female, aged 23 housewife, had suffered with hay fever continuously for eight years. During this time she had three attacks of asthma and one of urticaria. The asthma came with "colds" or after vaccine therapy. Attacks consisted of the usual symptoms with a feeling of heat over the head and face, extreme nervousness, headache, and inability to keep the eyes open. Symptoms were increased by crowds, and by all irritating fumes and dusts. Face powder had no effect. Her father had suffered with asthma. Positive reactions were obtained to orris root, chicken feathers, and an extremely severe reaction to an extract made from the dust of her own house.

Case 4. M. J. A., a white female, aged 38, housewife, had suffered with hay fever for two seasons, lasting from May until frost. Her symptoms were typical but came on spasmodically. She knew of nothing that aggravated the attacks. She had an idiosyncrasy for aspirin and stated that one five grain tablet would produce asthma in ten minutes. One niece had urticaria after taking quinine, and two children had suffered from urticaria and angio-neurotic edema repeatedly. Much to our surprise all tests with pollen extracts were negative but a very marked reaction was obtained to Winter wheat and lesser reactions to Spring wheat and whole wheat.

Case 5. V. McL., a white female, age 36, housewife, complained of hay fever at intervals for ten years and continually for the last year. Attacks came every day and were increased by some face powders, all dusts, ashes, furs, and by wheat flour. In the beginning, her attacks had come only between July and frost but had gradually changed to last the entire year. She had suffered from eczema while a baby and had had one attack of asthma. Positive reactions were obtained to orris root, wheat, corn, rice, cat hair, goose feathers, and oats from the inhalant group, and, to apple,

apricot, asparagus, cherry, onion, and tomatoes from the foods.

Case 6. A. F., a white female, age 26, complained of chronic colds since the age of remembrance with occasional exacerbations, coming most often in the Spring. Her symptoms were those of the usual hay fever, with those of deafness and nervousness exaggerated. She had suffered with urticaria about once a year. Her mother suffered with the Fall type of hay fever. Positive reactions were obtained to the pollens of hickory, walnut, maple, oak, and pine trees, and to those of orchard grass, Bermuda grass, and timothy. In addition the patient reacted to orris root, rice, house dust, goose feathers, horse dander, and to tomatoes.

Case 7. H. H., female, age 33, had suffered with hay fever from early Spring until frost every year for six years. Attacks came periodically and lasted from a few hours to several days. Her symptoms were sneezing, a profuse nasal discharge, stoppage of the nose, itching of the eyes and nose, deafness, vertigo, general bodily aching, profuse perspiration, and nausea. Attacks had occurred more frequently in her own home than elsewhere, and were increased by cold air, bathing the face, heat from an open oven, and by sweeping and dusting. An acute attack was always somewhat relieved by menstruation. One maternal aunt and one maternal uncle had asthma, one sister had eczema, one sister had urticaria, and one son had suffered practically all his life with occasional attacks of urticaria and angioneurotic edema. Positive reactions were obtained to orris root, rice, and to an extract of dust from her own house.

Case 8. L. C., a white female, age 34, stenographer, had suffered with all the symptoms of hay fever accompanied by a sensation of tightness in her chest almost every day for three years. Attacks usually came on every morning upon arising and lasted for about two hours, but sometimes occurred during the day. If she moved during the night while in bed, sneezing usually resulted. All symptoms always



ceased during menstruation. Menses had begun at the usual time of life, came regularly, but were very scant and lasted only two days. There had been no local pain with menstruation but a general bodily aching. All tests for sensitization were negative.

The above cases have been selected to demonstrate the following facts: First, that some cases suffering only from chronic colds have a definite sensitization. Second, that cases simulating true seasonal hay fever and presenting symptoms during the warm months only, may show no sensitiveness to pollens but are caused by other inhalants. Third, that some cases of apparently non-seasonal hay fever occurring throughout the entire year, are sensitive to the pollens and to other inhalants as well. Fourth, in many cases definite sensitiveness to foods can be demonstrated. Fifth, that in less than fifty per cent of the cases can the cause be suspected from the history, and, that in some cases, the history, by giving the opinion of the patient on the cause of the trouble, is decidedly misleading. Sixth, that in two cases attacks were definitely relieved during menstruation.

The treatment of the above cases, with the exception of case eight in which no sensitization could be demonstrated, consisted (a) in the removal of contact with the offending substance, when possible, (b) in graduated injections of a mixture of extracts from the inhalants that gave positive reactions, and (c) in omitting from the patients diet the articles of food that had given positive reactions. We have for use, when necessary, the ultraviolet ray light, but we have found it unnecessary in the average case.

Results from treatment have been uniformly good, usually quick, and in most instances marked improvement has been evidenced within the first few days of treatment. Some of the cases have had a return of symptoms in a mild form after several months, but have always been relieved by three to four injections of the specific extracts. Case eight was treated by the ad-

ministration of the extracts of corpus luteum and whole ovary both by mouth and intramuscularly. Improvement began at once and she has been free of symptoms for almost a year.

#### Summary:

1. The proper designation for the symptom complex formerly known by the names of hay fever, vasomotor rhinitis, and hyper-esthetic rhinitis, is atopic coryza.

2. In the cases of non-seasonal atopic coryza reported above, sensitiveness to the following substances has been demonstrated. Orris root, rice, house dust, the pollens, wheat flour, chicken feathers, goose feathers, cat dander, horse dander, corn meal, and a number of different foods.

3. Every case of non-seasonal atopic coryza should be tested with the entire inhalant group,—including the pollens,—with the foods, and with the bacteria.

4. The history is often misleading in determining the type and causes of any form of atopic coryza, because some cases presenting symptoms during the Spring and Summer months only are caused entirely by inhalants other than the pollens, while other cases occurring throughout the entire year are caused not only by other substances but by pollens as well.

5. The immunological treatment of cases of atopic coryza showing definite sensitization to the inhalants is uniformly successful.

6. In cases where no sensitiveness can be demonstrated, and underlying endocrine basis should be searched for, and after such basis has been established, proper treatment instituted. Administration of peptones, or of calcium salts with thyroid extract together with irradiation with the air-cooled ultraviolet light may be efficacious in such cases.

#### REFERENCES

1. Blackley. Hay Fever, London, 1873.
2. Dunbar. Berl. klin. wchnschr., 1905, Nos. 26, 28, 30.
3. Wolff-Eisner. Das. Heufieber, Munchen, 1906.
4. Noon. Prophylactic inoculation against hay fever. Lancet, 1911, i, 1572.
5. Freeman. Further observations on the treatment of hay fever by hypodermic inoculation of pollen vaccines. Lancet, 1911, ii, 814.
6. Doerr. Handbuch d. path. Org. kolle-Wasserman, 2nd Ed., 112, P. 947.
7. Coca and Cooke, Jour. Immun. 8, 763, 1923.
8. Meltzer. Bronchial Asthma as phenomenon of anaphylaxis. Jour. A. M. A., 1910, LV. 1021.

9. Hansel, Vasomotor Rhinitis. J. A. M. A., 82:15, Jan. 5, 1924.
10. Novak and Hollender. Influence of Ultraviolet Irradiation on the Calcium Content of Blood in Hay fever. Hyperesthetic Rhinitis, and the Asthmas. J. A. M. A., 81:2003, Dec. 15, 1923.
11. Simpson: The Basal Metabolism in Hyperesthetic Rhinitis, Bronchial Asthma, and in cases in which Roentgen Ray or radium has been applied to the Tonsils. Laryngoscope, 31:768, Oct. 1922.
12. Selfridge. Vasomotor Disturbances of the nose with Special Reference to Hay Fever. Laryngoscope, Oct. 1920.
13. Barcat. Treatment of Hay Fever by Radium and Roentgen Rays. Bull. de l'Academie Medecine, Paris, June 13, 1922, 38., Vol. LXXXVLL, P. 642.
14. Vallery-Radot, Haguenauer, and Watelet. Presse Medical, Sept. 1921.
15. Krogh. Significance of the Anaphylactic Theory in the Treatment of Vasomotor Rhinitis. Ugeskr. f. Laeger, Copenhagen, 95:339, May 10, 1923.
16. Walker. Observations on Hay Fever. Am. Otol. Rhinol., Laryngol. 31:660, Sept. 1922. Jour. A. M. A. Sept. 1920.

### DISCUSSION ON PAPER OF DR. HAL M. DAVISON

DR. ARTHUR C. WADE, Augusta: I wish to discuss this paper because I am a sufferer from Hay Fever myself. I think that those who suffer from the devilish affliction can well sympathize with those who suffer from the dread affliction. I have been a sufferer from Hay Fever as long as I can remember, for twenty-five or thirty years it would come on me about the twenty-third of August. In the fall of 1912, I left Augusta, and went to Put-Bay and in a day or two after reaching that resort I was very much relieved of the trouble, and was free of it for four years afterwards. Since then I have been a sufferer of the trouble except four years ago I took the Giant Ragweed Pollen extract, and was relieved or missed it that year. But last year I had it more severely in the spring, but missed in the fall. I wish to ask the doctor why it was that I had it in the spring of the year instead of the fall, after being affected so many years at one season. I never suffer from a cold, but when the Hay Fever strikes me I am absolutely fit for nothing. I am able to be up and about during the morning, but during the afternoon I have to give up and go to bed. A great many make light of Hay Fever, but I want to say that it is the most disagreeable, the most harrassing and the most weakening thing that one can be afflicted with. One has no appetite, does not wish to see or talk to any one, is nervous and altogether fit for nothing, and there is very

little relief unless you are kept full of some kind of opiate, or use Adrenalin or something of the kind regularly. I want to say to you gentlemen, that when you have a Hay Fever sufferer to come to you for medical treatment, for heaven's sake have pity on them and do not treat it lightly as I have known some to do, for it is the greatest suffering on earth.

DR. HAL M. DAVISON, Atlanta (closing): The answer is that one can have further sensitization develop at any time. I have patients who first have it in the spring and not in the fall, and then this will be reversed and they will have it in the fall and not in the spring. Why they do that no one knows. It is an inherited proposition and one's father may have had one kind while the children may have another.

Our results have been uniformly good under our treatment, but sometimes we have to repeat the treatment. My patient No. 8 was relieved entirely of all difficulty by means of ovarian extract.

(Read closing paragraphs from paper.)

### INSUFFICIENT TREATMENT OF SYPHILIS AND ITS RELATION TO NEURO-SYPHILIS

H. D. Allen, Jr., M. D.,  
Milledgeville, Ga.

In presenting the subject of insufficient treatment of syphilis and its relation to the later development of neuro-syphilis, it is well that I plead guilty, from the beginning, that I perhaps treat more cases of syphilis insufficiently than any other physician in the Tenth District, who works single handedly as I do. From a review of "What Is sufficient treatment," Figure 1 for foot note the main stress is laid upon treatment to prevent later neuro-syphilis, and there are even some who wish to indict the arsphenamines themselves as being responsible for the increased detection of cases of syphilis of the central nervous system. Quoting the consensus of opinions of Stokes, Keidel, Moore and Fordyce "Unless a physician feels himself competent to carry out all the necessary procedures in the treatment of any given case he should not at-



tempt to treat it at all." This opinion is given as to what the leading syphilographers feel about failure to control early syphilis, it causing the high incident of neuro-syphilis. My excuse for giving an insufficient treatment to syphilitics, is, to give some treatment to as many as is possible, and trust to the benefits of a minimum course, it being educational, and at the same time retards infectivity, insofar as grossly exposed lesions are closed completely or in part. Quoting the Chief Medical Officer, of the British Ministry of Health: "Obviously, the clinic should be efficient, but it must also be popular."

The prevalence of syphilis: Following the line of reasoning of L. Marcus, (*Social Hygiene*, October, 1921), which is perhaps, the best manner of arriving at the total number of venereal disease cases in the United States, (Ed. *Progressive Medical series*), I estimate that there are about seven hundred to seven and fifty cases of positive Wassermann in Baldwin County, exclusive of the Prison Farm and State Sanitarium. Baldwin County is an average county, in that the population of the State, divided by the population of Baldwin, gives a few over one hundred and fifty counties. The figure for the percentage of syphilis, for Georgia, in the second million drafted into the Army, was 13.9 per hundred. (Checked against some nine thousand Wassermann done here at the State Sanitarium, with approximately fifteen per cent positive. (Fig. 2 for foot note. With syphilis being three times as prevalent among men as women, and fifty per cent of infections being between the draft ages, twenty to thirty years, and 36.2 per cent of all cases, at this age, and congenital syphilis placed at the very high figure of three per cent. (Further local check: a little less than five per cent from two hundred Wassermann on boys at the training school here, and two positives among sixty female negro nurses at the State Sanitarium). Of the first four hundred and fifty, routine Wassermanns done in my clinic, twenty-five per cent were positive. This included one hundred and forty-six females and three hun-

dred and four males, approximately ninety per cent negroes. This is obviously much too high for an index of incidence, because there were many tests made on the consorts of those known to be infected. The incidence of thirty per cent in State Farm convicts and twenty-five per cent for insane negroes at the State Sanitarium, are also obviously extreme, in considering the incidence in civilian population, either black or white. Marcus' figure for total active venereal diseases for the United States is 8.12 per cent, with the ratio of syphilis to gonorrhea being 20:16.77. So, a five per cent incident for syphilis is near enough for a working hypothesis. This being no mean figure, when compared to the high initial incidence of tuberculosis, in the Framingham experiment of only one per cent.

If in New York State, one person out of twenty has syphilis, only about one out of twenty-six hundred is committed to a State Hospital with neuro-syphilis and one person out of every three hundred is in a State Hospital. (Statistics, New York State Hospital). In Georgia, about one person out of every seven hundred and fifty is in our one State Hospital for the Insane. Granting a high rate of ten per cent, or two hundred and fifty positive Wassermann syphilifers out of the four thousand patients in this institution; then, there is one person with syphilis in our State Hospital to each 7,500 persons in the State. From this, it is readily seen, admitting that complete treatment prevents neuro-syphilis, that about one person out of each three hundred and fifty cases of syphilis is committed to the State Sanitarium with neuro-syphilis, regardless of the kind or amount of treatment, or lack of treatment received. If only one person out of each three and a half neuro-syphilifers is committed to the State Sanitarium, then, only one per cent of syphilitics develop permanent neuro-syphilis. This rate of one per cent is just eight times higher than the Metropolitan rate for Industrial Policy holders, which rate is 13.1 per hundred thousand deaths, 1921. At a one per cent rate, this would give a syphilitic rate



of eight per cent for this group which is a conservative figure. Fordyce and Rosen, however, find abnormal spinal fluids in about twenty-five per cent of their cases and Moore, (Johns Hopkins) ninety-four pathological fluids from three hundred and fifty-two syphilitics in various stages of the disease. They admit, however, that time has not elapsed sufficiently to determine what per cent of these cases go on to general paralysis, tabes, or symptomatic-neurosyphilis. This does, however, indicate that the invasion of the central nervous system is early in the stage of the disease. Moore thinks the negro less likely to develop neurosyphilis.

At the State Sanitarium, two hundred and thirty-four routine spinal fluid examinations, 1922, showed twenty per cent pathological. Of this number of fluids, only one hundred and seventeen had positive blood Wassermanns. Twelve pathological fluids with negative Wassermanns, (blood.) Forty-five positive fluids out of a hundred and seventeen positive bloods. This shows how easily a concentration of syphilitics under a special condition can distort estimates of a general incidence of syphilis.

The responsibility for Neuro-Syphilis: When the G. P. or even pathological spinal fluids in our State Hospital are compared with the general population of our country or any locality, it is insignificant, being 0.005 per cent. But, if we can save these twenty-five thousand from the State Hospitals, it is well worth any reasonable economical effort on the part of those treating syphilis. To refer all syphilitics to competent syphilographers is not reasonable, economical, nor even possible, so that much still rests with the general practitioner and small poorly equipped clinics to do the best they can and stoically bear their grave responsibilities.

Fraser, (British Journal of Dermatology), summarizes the responsibility in this way:

- (a) The tendency to treat primary syphilis en-masse.
- (b) The method of working to a mechanical time table.

- (c) The blindfold method of working for a serological, rather than a clinical cure.

- (d) Losing sight of the nervous system in regards to the patient's future and the tendency to undertreat.

Rapid sterilization robs the cerebro-spinal axis of anti-bodies. Possible damage to axis by anxiety, such as War, a predisposing factor. For securing the safety of the cerebro-spinal axis the early invasion is taken for granted. The occurrence of neurosyphilis is influenced by the patient's resistance, the capacity of the central axis for anti-bodies, the state at which treatment is inaugurated, the kind of treatment and the life cycle of the spirocheta pallida. Stokes also urges conservatism, because so short a time has elapsed since the discovery of the principal drugs and so little is known of the ultimate pathology, immunology, and parasitology of syphilis.

The usually adopted treatments are too well known to warrant any detailed description. Fordyce's method of treatment, as nearly as I can remember, in 1917 and 1918, were briefly, this: Twelve doses of salvarsan, six given at weekly intervals, six weeks of gluteal injections of mercury and six more weekly doses of salvarsan, with or without mercury, this to be repeated p. r. n. q., six months. The distance I have departed from this is perhaps little short of criminal, but no one will ever accuse me of failing to appreciate simplicity and conservatism. What is needed is a standard treatment, but this is also true for every disease. However in standardizing it is well to work from the easy simple and conservative extreme, as well as from a standpoint of efficiency, which maybe complex and often hazardous in inexperienced hands, I feel my conservatism justified so long as I am not depriving the syphilifer of more efficient treatment and not charging him or her directly for the little given. I don't believe that one, two, or even three shots of Neo-arsphenamine given to a negro materially increases his or her liability of becoming a charge on the State as a Neuro-

syphilitic, if he or she fails to come for more. I do believe that he or she is immediately benefited, often, and his or her infectivity is slightly inhibited, providing his or her virility is not too greatly increased.

Treatment: The course of treatment I have adopted is a slight extension of the assumption that three doses of arsphenamine would sterilize a case of syphilis sufficiently to prevent partially the spread of the disease through promiscuous venery. Lack of funds prevent me from giving accessory medicine in the way of mercury, and iodines, and, as I obtain the neo-arsphenamine free from the Venereal Department, State Board of Health, neo-arsphenamine is my choice, as it is administered more quickly and requires less distilled water. The doses are graduated from 0.3 to 0.6 Gms. and are given at weekly intervals, except in primary cases, the first three doses are given in the first week. I mix the drug in the original ampoule, and use 10 cc. of distilled water, injecting with a twenty-six or twenty-four hypodermic needle. After six injections, a month's rest is given, with or without mixed treatment per oris, depending upon the patient's ability to buy same. The patient returning in a month, another blood test is taken before continuing treatment further, unless there is obvious reason for continuing without waiting to hear from the blood Wassermann.

Reviewing the first two hundred cases treated, which brought me up to July 15, 1922, of these, sixty-one were obviously syphilitic in an early stage and no initial Wassermans were made. Thirty-one were treated in spite of a negative Wassermann but were reported as syphilitic on account of presenile neurological findings, or very positive histories with subjective improvement from treatment, or the several consorts of known syphilifers; with negative bloods but clinical symptoms. Many of the most striking benefits of treatments were in this group, as I believe is a rather general experience. One hundred and eight gave initial positive Wassermans, here were a

few disappointments in the expected response to treatment, but, as a whole, results seemed to be good. At this time, twenty-one had returned for follow up blood tests. Of these, seventeen were negative, at least after six months had elapsed, four were reported weakly positive after one month, but were rendered negative with four additional injections of neo-arsphenamine, and have remained so at the end of one year. Recently, I have had one case which is still positive after eighteen injections in the period of six months. I feel that these cases have been my most punctual in attendance, and this makes the result with them above the average. My most irregular in attendance are the early stage cases, and I feel here that immediate improvement with the apparent normal state of well being is the cause of indifference in this class.

Now, as I am about reaching the halfway point in my estimate of seven hundred cases, for the county in round numbers, I have given fifteen hundred doses of neo-arsphenamine to about three hundred and fifty syphilites. My clinic has fallen from a maximum of thirty-five admissions per month to a recent average of less than ten or fully a reduction of fifty per cent in early stages of syphilis. Yet, I have many reasons to believe that the popularity of my method is increased, and the nature of the work better advertised, though I am fully cognizant of some influence from the recent increase in the negro exodus. This, however, I believe is minimal as we expect a removal of the healthy to predominate under the conditions conducive to the migration.

Conclusions: Assuming a 5 per cent rate of syphilis for the population of a county a minimum course of treatment with neo-arsphenamines for 50 per cent of the infectious syphilitic apparently reduces the incident of infections.

It is obvious that a reduction of infections will reduce the number of later Neuro-syphilites.

To prevent damage to the Cerebro-spinal axis in syphilites under treatment regardless of conservatism or intensity of treat-

ment the patient must be kept under both clinical and serological observation over a period of years or even the life of the patient.

Only a marked refinement in serological studies can promise a standard cure.

Until we do have a standard cure a course of treatment a little in excess of enough to apparently cure open lesions seems to inhibit infections.

## NEW AND NON-OFFICIAL REMEDIES

### Abbott Laboratories:

Tablets Benzyl Fumarate-Abbott, 5 grains.

### Gilliland Laboratories:

Diphtheria Toxin Antitoxin Mixture 0.1 L.

### Hynson, Westcott and Dunning:

Sealed Tubes Mercurochrome—220 Soluble 0.5 Gm.

### Lederle Antitoxin Laboratories:

Intracutaneous Tuberculin for the Mantoux Test.

### Lehn and Fink:

Corpus Luteum—L. and F. Desiccated:

Capsules Corpus Luteum—L. & F. Desiccated, 2 grains.

Capsules Corpus Luteum—L. & F. Desiccated, 5 grains.

Tablets Corpus Luteum—L. and F. Desiccated, 2 grains.

Tablets Corpus Luteum—L. and F. Desiccated, 5 grains.

Ovarian Residue—L. and F. Desiccated:

Capsules Ovarian Residue—L. and F. Desiccated, 5 grains.

Tablets Ovarian Residue—L. and F. Desiccated, 2 grains.

Tablets Ovarian Residue—L. and F. Desiccated, 5 grains.

Ovarian Substance—L. and F. Desiccated:

Capsules Ovarian Substance—L. and F. Desiccated, 2 grains.

Capsules Ovarian Substance—L. and F. Desiccated, 5 grains.

Tablets Ovarian Substance—L. and F. Desiccated, 2 grains.

Tablets Ovarian Substance—L. and F. Desiccated, 5 grains.

### Mallinekrodt Chemical Works:

Mallinekrodt Tetrabromphenolphthalein Sodium salt:

Mallinekrodt Tetrabromphenolphthalein Sodium Salt, 5 Gm. Ampules.

### H. K. Mulford Co.:

Neorobin:

Vacuum Sealed Tubes Neorobin, 1 grain.

Vacuum Sealed Tubes Neorobin, 5 grains.

### New York Quinine and Chemical Works:

Euquinine—N. Y. Q.

### E. R. Squibb and Sons:

Bacillus Bulgaricus—Squibb.

### Nonproprietary article:

Tetrabromphenolphthalein Sodium.

### Hoffmann-LaRoche Chemical Works:

Seeacornin

Thigenol.

### Intarvin Co., Inc.

Intarvin.

### Eli Lilly and Co.

Ampules Ouabain, 0.0005 Gm. (1/128 grain)—Lilly.

Hypodermic Tablets Strophanthin 1/100 grain—Lilly.

Hypodermic Tablets Strophanthin 1/120 grain—Lilly.

Iletin (Insulin-Lilly) U-80.

### Merek and Co.

Benzyl Succinate-Merek.

### Parke, Davis and Co.

Ampoules Adrenalin Chloride Solution Rx 1, 1:10000, 1 Ce.

Ampoules Adrenalin Chloride Solution Rx 2, 1:2600, 1 Ce.

Ampoules Adrenalin Chloride Solution 1:1000, 1 Ce.



# THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Profession of Georgia.

65 Forrest Ave., Atlanta, Ga.

JANUARY, 1925

ALLEN H. BUNCE, M. D., Editor  
 M. C. PRUITT, M. D., Business Manager  
 Publication Committee  
 CHAS. USHER, M. D.  
 S. J. LEWIS, M. D.  
 T. C. THOMPSON, M. D.

Articles are accepted for publication on condition that they are contributed solely to this Journal.

Manuscripts should be typewritten, double-spaced, and the original (not the carbon copy) submitted. Used manuscript is not returned unless requested.

Communications and items of general interest to the profession are invited from all parts of the State. We especially invite county society secretaries to send us information of happenings in the county that would be of interest to the members throughout the State.

## Editorial Department

### DR. STEWART R. ROBERTS ELECTED PRESIDENT OF THE SOUTHERN MEDICAL ASSOCIATION

At the recent meeting of the Southern Medical Association in New Orleans, Dr. Stewart R. Roberts, of Atlanta, was unanimously elected President for the ensuing year. For a number of years Dr. Roberts has been prominent in both national and international medical circles and his election is not only a tribute to his personal and scientific qualifications but particularly to the medical profession of Georgia, as he is the first President to be chosen from Georgia since the Association became a real factor in southern medicine. It is not necessary for us here to enumerate the many positions of trust which have been held by Dr. Roberts or the many honors which have been conferred upon him, since these are familiar to us all. However, we can say without fear of contradiction that the Association honored itself in honoring Dr. Roberts. The Presidential Chair has never been occupied by one more eminently qualified from every standpoint.

To show their appreciation of the work

which Dr. Roberts has done for medicine in Georgia and the South, the members of the Fulton County Medical Society entertained him at a banquet at the Capital City Club on December 10th. Dr. Phinizy Calhoun acted as toastmaster and talks were made by Drs. W. E. Person, Allen H. Bunce, E. C. Thrash and W. B. Emery. Dr. Roberts responded with an impromptu discussion of the problems confronting the Southern doctor, and stated that he considered his election more as a tribute to the doctors of Georgia than to himself.

The next annual meeting of the Southern Medical Association will be held in Dallas, Texas, November, 1925. A large delegation from Georgia will be on hand.

### MEDICAL ASSOCIATION OF GEORGIA AND GEORGIA EDUCATIONAL ASSOCIATION COOPERATE IN HEALTH WORK

The joint Committee, representing the Medical Association of Georgia and the Georgia Educational Association, held its first meeting Saturday, December 27, 1924, in the Chamber of Commerce, Atlanta. The purpose of the meeting was to carry on the work of cooperation as outlined by both National Associations with a view to obtaining a closer cooperation between the Georgia Educational Association and the Medical Association of Georgia in health matters pertaining to the individual and the community.

Those present representing the Medical Association of Georgia were: Dr. J. O. Elrod, Forsyth; Dr. Allen H. Bunce, Secretary-Treasurer, Atlanta; Dr. Theo Toepel, Chairman, Committee on Health and Public Instruction, Atlanta; Dr. H. B. Neagle, Augusta and Dr. J. A. Thrash, Columbus, members of the Committee. The State Board of Health was represented by Dr. T. F. Abererombie, Commissioner of Health. The Educational Association was represented by Mr. Roland B. Daniel, Superintendent of Schools, Columbus; Mr. Kyle T. Alfriend, Secretary of the Association, Forsyth; and Mr. R. I. Knox, Superintendent of Schools, Jackson.

Dr. Elrod presided over the meeting and Mr. Alfriend acted as secretary. The object of the meeting was stated by Dr. Toepel, after which there was a free discussion of the health problems, especially those pertaining to the rural schools. A great deal of modern health work is being done in the schools of the larger cities but less is being done in the smaller communities. Dr. Abercrombie strongly advocated the adoption of the Ellis Health Law by all the counties in the State as the most important forward step. This was heartily endorsed by the committee. Mr. Daniel reviewed the work which has been done in Columbus by the cooperation of the schools and department of health and suggested that the first effort be concentrated on two diseases—malaria and hookworm. Dr. Neagle inquired as to the amount of health instruction being given in the normal schools of the State, stating that it is necessary that the teachers be properly trained in health matters if they are to assist in the work. After a free discussion by all members present, a subcommittee composed of Dr. Abercrombie, chairman, Mr. Knox and Dr. Toepel was appointed to make an investigation to learn just what is being done in the various schools throughout the state in health matters and report back to the full committee with recommendations. This subcommittee was also instructed to solicit the cooperation of the county and city school superintendents.

We believe this to be the beginning of the most important health work which has ever been undertaken in Georgia. It will lead to a better understanding and closer cooperation between the individual physician, the boards of health and the schools.

### REPORT OF THE COMMITTEE ON SCIENTIFIC WORK

The Committee on Scientific Work desires the cooperation of every member of the Association in helping to arrange the best program possible for the next Annual Meeting, which is to be held in Atlanta, in May. The largest attendance in the history of the Association is expected. Atlanta assures us a royal welcome.

In order that there may be prepared a well-balanced and representative program, we wish to call the attention of all members to the following rules governing the Scientific Work:

1. Any member of the Association in good standing may send in a title for the program.

2. All titles must be sent in in writing on or before March 15th. They may be sent to the Secretary or to either of the members of this committee. (By-Laws, Chap. VI, Sec. 2.)

3. By-Laws, Chapter VIII:

“Section 1. No address or paper before the Association shall occupy more than fifteen minutes in its delivery; and no member shall speak longer than five minutes, nor more than once on any subject, except by unanimous consent.

“Section 2. All papers read before the Association, or any of the sections shall become its property. Each paper shall be deposited with the Secretary when read.”

4. Resolution adopted 1921: “Resolved, That a member who sends in a title of a paper to be placed on the program and is not present to read the paper shall pay the penalty of not having the opportunity to appear on the program for two years, unless he presents an excuse acceptable to the Committee on Scientific Work.”

5. All papers must be typewritten, doublespaced and on one side of the paper. Each paper should bear name and address of author and should be correct from the standpoint of spelling, grammar, rhetoric, etc.

6. No member will be placed on the program whose dues for the current year have not been paid.

7. Other things being equal, preference will be given to those who were not on the program last. We seek your aid and cooperation and assure you that we shall endeavor to serve you for the best interest of the Association.

A. R. Rozar, Chairman.

Hugh N. Page.

Allen H. Bunce.

Com. on Scientific Work.

## District and County Societies

The Secretary of each county society shall report to the Journal of the Medical Association of Georgia full minutes of each meeting and forward to it all scientific

papers and discussions which the society shall consider worthy of publication.—Constitution and By-Laws, Chap. VII, Sec. 15.

1. Demmond, E. Carson, Savannah.
2. Wood, A. W., Albany.
3. Greer, Chas. A., Oglethorpe.
4. Blackmar, Francis B., Columbus.
5. Clay, Grady E., Atlanta.
6. Hawkins, T. I., Griffin.

7. McCord, M. M., Rome.
8. Carter, D. M., Madison.
9. Bennett, J. C., Jefferson.
10. Lee, F. Lansing, Augusta.
11. C. B. Greer, Brunswick.
12. Cheek, O. H., Dublin.

### THIRD DISTRICT MEDICAL ASSOCIATION

The Dooly County Medical Society acted as host to the Third District Medical Association at Vienna, November 19, 1924. The meeting was called to order by the President, Dr. F. M. Martin, Shellman. The Invocation was given by Rev. J. H. Jenkins. Hon. Watts Powell welcomed the Association in behalf of the City. Dr. H. A. Mobley, of Vienna, gave the Address of Welcome on behalf of the Third District Medical Society, with response by Dr. E. C. McCurdy, Shellman. A brief but cordial welcome was given the visiting doctors on behalf of the city by Senator Walter F. George. The following papers were read:

"Focal Infection," Dr. E. B. Davis, Byromville. Discussed by Drs. M. R. Smith and R. E. McGill.

"Diagnostic Errors," Dr. Newdigate M. Owensby, Atlanta. Discussed by Drs. W. A. Miller and Jno. T. Moore.

"Remarks on Prostatic Diseases," Dr. J. T. Stukes, Americus. Discussed by J. F. Lunsford and W. L. Story.

"Treatment of High Blood Pressure," Dr. Allen H. Bunce, Secretary Medical Association of Georgia, Atlanta. Discussed by Drs. R. M. Ware and Steve P. Kenyon.

"Result in Treatment of 429 Cases of Carcinoma of Cervix Uteri by Radium," Dr. Arthur C. Primrose, Americus. Discussed by Drs. J. C. Patterson and C. C. Harrold.

"Choice of Anesthesia in Surgical Conditions of the Rectum," Dr. Marion C. Pruitt, Business Manager of the State Medical Journal, Atlanta. Discussed by Drs. B. J. Wise and B. L. Bridges.

"My Ideals for the Medical Association

of Georgia," Dr. J. O. Elrod, President of the Medical Association of Georgia, Forsyth.

Report of Councillor, Dr. V. O. Harvard, Arabi, Councillor Third District Medical Society.

Dr. E. B. Davis, of Byromville, was elected President to succeed Dr. F. M. Martin, of Shellman. Dr. J. F. Stukes, of Americus, was elected Vice-President to succeed Dr. Guy Chappell, of Dawson. Dr. Chas. A. Greer, of Oglethorpe, was elected to succeed himself as Secretary-Treasurer.

At this meeting, the doctor's wives formed an Association. Mrs. R. H. Pate was elected as District President and Mrs. E. B. Davies as Secretary.

The Entertainment Committee was in charge of Dr. V. C. Daves. Drs. T. R. Moye and J. L. Lee completed this Committee. Dr. T. F. Bivins was Chairman of the Arrangement Committee, assisted by Drs. T. R. Moye and R. H. Pate. Dr. F. E. Williams served as Chairman of the Invitation Committee.

### TROUP COUNTY MEDICAL SOCIETY

The annual meeting of the Troup County Medical Society was held in LaGrange, December 18, 1924. The following officers were elected for the year 1925: President, Dr. B. C. Daniel, Hogansville; Vice-President, Dr. Thomas W. Taylor, West Point; Secretary-Treasurer, Dr. Ruben S. O'Neal, LaGrange; Delegate, Dr. H. H. Hammett, LaGrange; Alternate, Dr. C. W. Harvey, Hogansville; Board of Censors, Drs. W. H. Hadaway, Ruben S. O'Neal and C. A. P. Ebbert.

Meetings are to be held every two months; three to be held in LaGrange, two in West Point and one in Hogansville.



The next meeting will be held in La-Grange the last Thursday in January.

R. S. O'NEAL, Secretary.

### THOMAS COUNTY MEDICAL SOCIETY

The Thomas County Medical Society met in regular session in the Medical Building in Thomasville, Dec. 10, 1924. The meeting was called to order by the President, Dr. J. T. King, at eleven a. m.

The minutes of the last meeting were read and adopted. Next on the program were the scientific papers. The first of these was a paper by Dr. B. H. Minchew, of Waycross. Dr. Minchew's paper was entitled, "Your Hospital; Your Duties to it and to Your Profession." This paper was particularly appropriate at this meeting in view of the magnificent hospital now being erected by Mr. J. F. Archbold in this city. It was well received and altho not calling for a great deal of discussion, Dr. Minchew was complimented upon his paper and the views expressed therein.

The second paper was read by Dr. C. H. Ferguson, of Thomasville, entitled "Pernicious Anemia." This was very ably presented and showed evidence of much painstaking in its preparation. Dr. Ferguson went especially into the clinical symptoms and blood picture of this disease in its different phases and stages. It was discussed by Drs. Cheshire, Little, Watt and B. B. Steedly of Atlanta.

The third paper was read by Dr. B. B. Steedly, of Atlanta. Dr. Steedly's paper, entitled "Mammary Cancer," was a very comprehensive survey of this disease, both in his classification of the different types of growth, and his discussion of the best mode of treatment of each. His paper indicated that altho surgery is still our sheet anchor in treatment, we have much to hope for in the ever improving methods of radiation. His paper was discussed by Drs. Wall, Little and Watt of Thomasville, and Dr. B. H. Minchew of Waycross.

At the conclusion of Dr. Steedly's paper the meeting adjourned to the auditorium of the Medical Building where a duck dinner had been prepared and was served by the

Student nurses of the Thomasville City Hospital. This was greatly enjoyed by the members and visitors present. We were gratified to have with us several physicians from towns in adjoining counties.

After luncheon the meeting reassembled in the meeting room on the first floor and business was attended to as follows: Resolutions were passed to the effect that this Society endorses the work being done by the Red Cross nurse in the County and recommended that the County Commissioners pay half her salary as was recommended by the last grand jury.

Drs. Moore and Jarrell were appointed by the chair to act in advisory capacity with the County Health Officer as to the next year's activities.

Dr. Arthur Wilbur DeLoach was elected a new member. Dr. E. K. McLean was appointed to serve as member of Censors Committee, succeeding Dr. Little.

Dr. C. K. Wall as delegate and Dr. C. H. Watt as alternate to the State meeting were appointed by the chair.

Officers for the next year were elected as follows:

President: Dr. S. L. Cheshire, Thomasville; Vice president: Dr. Henry Jones, Coolidge; Secretary and Treasurer: Dr. C. K. Wall, Thomasville.

As there was no further business the meeting was adjourned.

The Secretary wishes to express the thanks of the Society to the doctors from Waycross and Atlanta for coming before us with their excellent papers and hope that we may again have them with us.

C. K. Wall,

Secretary-Treasurer,

Thomas County Med. Society.

### WARE COUNTY MEDICAL SOCIETY

The annual meeting of the Ware County Medical Society was held Wednesday, December 3, 1924. Dr. D. M. Bradley presided with Dr. J. E. Penland. The following officers were elected for 1925:

President, Dr. K. McCullough, Waycross, Vice-president: Dr. W. D. Mixson, Waycross.

Secretary-Treasurer: Dr. J. E. Penland, Waycross.

Delegate: Dr. W. F. Reavis, Waycross.

Alternate: Dr. J. E. Penland, Waycross.

Board of Censors: Dr. H. J. Carswell, C. M. Stevens and R. C. Walker.

Interesting papers were read by Drs. B. M. Williams, W. C. Hafford, W. F. Reavis, Kenneth McCullough, J. H. Latimer, H. J. Carswell and J. D. Bagley.

The Waycross Journal-Herald proffered use of a column each week to the Ware County Medical Society to be used for the betterment of general health conditions.

Drs. W. F. Reavis, H. J. Carswell and W. D. Mixson were appointed as a Committee to appear before the next Grand Jury urging adoption of the provisions of the Ellis Health Law.

Those present at the meeting were Drs. D. M. Bradley, K. McCullough, W. F. Reavis, B. H. Minchew, W. M. Lott, B. M. Williams, George N. MacDonnel, J. B. Bagley, C. L. Drew, W. D. Mixson, H. J. Carswell, J. H. Latimer, E. B. Mitchell and J. E. Penland.

J. E. Penland, M. D.,  
Secretary.

### COUNTY SOCIETIES REPORTING FOR 1925

On December 31, 1924, the following 12 County Societies had sent in their reports for 1925, including 3 counties reporting 100 per cent, with a total of 109 paid up members:

#### Hall County Medical Society

Dr. Pratt Cheek, Secretary of the Hall County Medical Society was the first to send in his report, enclosing a check covering State dues for 18 members. The list of newly elected officers will be published in the February issue.

#### Randolph County Medical Society—100%

Randolph County gets the Blue Ribbon as the first 100% Society.

The Randolph County Medical Society announces the following officers for 1925:

President—W. W. Crook, Cuthbert.

Vice-president—Loren Gary, Georgetown.

Secretary-Treasurer—G. Y. Moore, Cuthbert.

Delegate—J. C. Patterson, Cuthbert.

Alternate—E. C. McCurdy, Shellman.

Board of Censors—F. D. Patterson, E. C. McCurdy and F. S. Rogers.

Dr. Moore was the first Secretary to report 100 per cent membership for 1925, and the second to send in his report. His report was received Dec. 9th.

#### Dougherty County Medical Society—100%

The Dougherty County Medical Society announces the following officers for 1925:

President—I. W. Irvin, Albany.

Vice-president—L. E. Welch, Albany.

Secretary-Treasurer—J. A. Redfearn.

Dr. Redfearn made a noble effort to report the first 100 per cent Society. He sent a telegram reporting for Dougherty on December 10th.

#### Thomas County Medical Society

The Thomas County Medical Society announces the following officers for 1925:

President—S. L. Cheshire, Thomasville.

Vice-president—Henry Jones, Coolidge.

Secretary-Treasurer—C. K. Wall, Thomasville.

Dr. E. K. McLean to succeed Dr. A. D. Little on the Board of Censors.

Delegate—Dr. C. K. Wall, Thomasville;

Alternate—C. H. Watt, Thomasville.

#### Pike County Medical Society—100%

The Pike County Medical Society announces the following officers for 1925:

President—No election.

Vice-President—No election.

Secretary-Treasurer—M. M. Head, Zebulon.

Delegate—J. H. Grubbs, Molena.

Alternate—J. R. Graves, Zebulon.

Board of Censors—R. A. Mallory, J. H. Grubbs, J. R. Graves.

#### Cherokee County Medical Society

The Cherokee County Medical Society announces the following officers for 1925:

President—J. M. Bates, Canton.

Vice-president—S. R. Harbin, Canton.

Secretary-Treasurer—Geo. C. Brooke, Canton.

Delegate—Geo. C. Brooke, Canton.

Alternate—J. T. Pettit, Canton.

Board of Censors—N. J. Coker, R. M. Moore and J. R. Boring.

#### **Walker County Medical Society**

The Walker County Medical Society announces the following officers for 1925:

President—M. W. Spearman, Chickamauga.

Vice-president—D. W. Hammond, LaFayette.

Secretary-Treasurer—J. H. Hammond, LaFayette.

Delegate—J. M. Underwood, LaFayette.

Alternate—M. W. Spearman, Chickamauga.

Board of Censors—J. M. Underwood, H. F. Shields and J. P. Wood.

#### **Stewart-Webster Counties Medical Society**

The Stewart-Webster Counties Medical Society announce the following officers for 1925:

President—G. G. Lunsford, Weston.

Vice-president—J. H. Foster, Preston.

Secretary-Treasurer—M. Walton, Lumpkin.

Delegate—J. M. Kenyon, Richland.

Board of Censors—J. F. Lunsford, R. H. Allen and J. M. Kenyon.

#### **Troup County Medical Society**

The Troup County Medical Society announces the following officers for 1925:

President—B. C. Daniel, Hogansville.

Vice-president—T. W. Taylor, West Point.

Secretary-Treasurer—R. S. O'Neal, LaGrange.

Delegate—H. H. Hammett, LaGrange.

Alternate—C. W. Harvey, Hogansville.

Board of Censors—W. H. Hadaway, R. S. O'Neal, C. A. P. Ebbert.

#### **Lowndes County Medical Society**

The Lowndes County Medical Society announces the following officers for 1925:

President—A. C. Little, Valdosta.

Vice-president—P. C. Quarterman, Valdosta.

Secretary-Treasurer—Joe A. Thomas, Valdosta.

Delegate—Frank Bird, Valdosta.

Alternate—Joe A. Thomas, Valdosta.

#### **Tift County Medical Society**

The Tift County Medical Society announces the following officers for 1925:

President—J. M. Price, Tifton.

Vice-president—C. S. Pittman, Tifton.

Secretary-Treasurer—W. T. Smith, Tifton.

Delegate—W. H. Hendricks, Tifton.

Alternate—N. Peterson, Tifton.

#### **Clayton-Fayette Counties Medical Society**

The Clayton-Fayette Counties Medical Society announces the following officers for 1925:

President—G. W. Wallis, Fayetteville.

Vice-president—T. C. Cannon, Jonesboro.

Secretary-Treasurer—H. D. Kemper, Jonesboro.

#### **NEWS ITEMS**

Dr. Theo. Toepel announces the removal of his offices from 78 Forrest Avenue to 65 Forrest Avenue, Atlanta. Dr. Toepel is the newly elected President of the Fulton County Medical Society.

Dr. W. A. Gardner announces the opening of his offices at 79 Forrest Avenue, January 1, 1925. Practice limited to Nervous and Mental Diseases. Office hours 11 to 1 and 3 to 5. Dr. Gardner is now and has been for the past several years Associate Medical Director of the Cheston King Sanitarium, Stone Mountain, Ga.

Dr. Ferdinand W. Hinkle has removed his offices from 211½ Lee Street to Suite 313 Atlanta National Bank Building, Atlanta. Dr. Hinkle is a member of the Fulton County Medical Society.

Dr. William A. Flick, who formerly had offices in the Hurt Building, is now located in Suite 1008 Atlanta National Bank Building, Atlanta. He is a member of the Fulton County Medical Society.



Dr. Louis Holtz has returned from Europe where he studied two years at the University of Berlin doing post-graduate work in Diseases of the Stomach and Intestines, to which he will limit his practice. Dr. Holtz has opened his offices in the Hurt Building, Atlanta.

---

Dr. Robert Miller Harris announces the opening of his offices in the Calumet Building, Miami, Florida. Practice limited to Internal Medicine.

---

Dr. M. P. Sporeman, formerly of Tifton, has moved to Manatee, Florida, where he will continue to practice his profession. For the past two years Dr. Sporeman has been the competent Secretary-Treasurer of the Tift County Medical Society.

---

Dr. Mercer Blanchard, of Columbus, was elected President of the Muscogee County Council of Health and Public Health Education to succeed Dr. J. M. Anderson, of Columbus, who was honored with the office of First Vice-president. Both Drs. Blanchard and Anderson are members of the Muscogee County Medical Society, Dr. Anderson having represented his Society as Delegate at the 1924 meeting in Augusta.

---

Dr. J. W. Palmer, of Ailey, was re-elected Secretary of the Association of Surgeons of the Seaboard Air Line Railway at the Meeting held in Sarasota, Florida, December 9-10th. Dr. Palmer represented The Montgomery County Medical Society as Delegate at the last annual meeting. He also attended the A. M. A. meeting during 1924, which was held in Chicago, as Delegate from the Medical Association of Georgia.

---

Drs. R. M. Ware and J. M. J. Luke, of Fitzgerald, were hosts to the Ben Hill County Society at a Banquet at the Empire Hotel December 3, 1924, the occasion being the annual meeting of the Society. The presence of the wives and daughters of the doctors helped to make this one of the most successful and enjoyable meetings of the Society.

Dr. J. P. Kennedy, City Health Officer of Atlanta and a member of the Fulton Medical Society, was elected as Chairman to introduce "Health Week" and its activities to Atlanta. The week of May 10th has been selected as the week for health demonstrations.

---

The members of the Telfair County Medical Association gave themselves a quail supper at the Masonic Hall in Helena, Tuesday, December 9th.

---

Dr. T. C. Thompson, of Vidalia and a member of the Toombs County Medical Society and Councillor from the Twelfth District, was host to the members of the Tri County Medical Society. The meeting was held at the Vidalia Hospital, Thursday, December 11, 1924. Dr. Thompson, together with Dr. J. E. Mercer, of Vidalia and a member of the Toombs County Medical Society, attended the meeting of the Tatnall County Medical Society in Reidsville, December 8, 1924.

---

Drs. F. D. and J. C. Patterson, members of the Randolph County Medical Society, have opened their new Hospital to the public. The equipment is new and modern in every respect and Cuthbert has just cause to be proud of the Patterson Hospital.

---

The Ware County Medical Society and three civic clubs of Waycross are doing everything possible in working for the adoption of the Ellis Health Law for Ware County. Committees from these bodies appeared before the Ware County Grand Jury urging the adoption of this Act. Dr. B. H. Minchew, of Waycross, represented the Kiwanis Club and Dr. George N. MacDonnell, also of Waycross, represented the Ware County Medical Society.

---

Camilla is making a successful fight to exterminate the malaria mosquito and all other mosquitoes. Mitchell County is the first County in the State to appropriate money to battle against malaria, which was begun about three years ago.

### MACON HOSPITAL STAFF

Dr. C. L. Ridley, of Macon, City and County Health Officer, was chosen Chairman of the Executive Committee of the Macon Hospital at the annual meeting of the Commissioners, December 8, 1924. The following members of the Bibb County Medical Society were also given appointments:

Executive Committee: Dr. C. L. Ridley, Chairman; Dr. Carl Anderson, Dr. C. H. Richardson, Jr., Dr. G. Y. Massenburg, and Dr. W. J. Little.

Division One: Dr. W. J. Little, Surgery; Dr. Herring Winship, Medicine; Dr. T. E. Rogers, Diabetes; Dr. G. T. Miller, Gynecology; Dr. T. A. Hurley, Obstetrics; Dr. R. L. Cater, Jr., Pediatrics; Dr. T. E. Blackshear, Genito-Urinary Diseases; Dr. D. T. Henderson, Eye, Ear, Nose and Throat; Dr. J. M. Sigman, Skin Diseases and Dr. W. A. Newman, Orthopedic Surgery.

Division Two: Dr. G. Y. Massenburg, Surgery; Dr. Fred L. Webb, Medicine; Dr. T. E. Rogers, Diabetes; Dr. C. H. Richardson, Jr., Gynecology; Dr. B. M. Johnson, Obstetrics; Dr. B. Bashinski, Pediatrics; Dr. E. Corn, Genito-Urinary Diseases; Dr. C. L. Pennington, Eye, Ear, Nose and Throat; Dr. J. M. Sigman, Skin Diseases and Dr. W. A. Newman, Orthopedic Surgery.

Division Three: Dr. O. H. Weaver, Surgery; Dr. T. E. Rogers, Diabetes; Dr. J. C. Anderson, Gynecology, Dr. O. R. Thompson, Obstetrics, Dr. T. D. Walker, Jr. Pediatrics; Dr. W. W. Meriwether, Genito-Urinary Diseases; Dr. J. M. Sigman, Skin Diseases and Dr. W. A. Newman, Orthopedic Surgery.

### ANNUAL MEETING ATLANTA ANTI-TUBERCULOSIS ASSOCIATION

The members of the medical staff of the Atlanta Anti-Tuberculosis met December 11th for their last meeting of 1924.

This meeting was a combination of social and professional interest. At 6:30 the nurses of the Association served the doctors with a Christmas dinner and after this festivity, Dr. C. C. Aven, Chief of Staff called the meeting to order.

Dr. Aven announced that in view of the fact that this was the last meeting for 1924 they were presenting some analyses of the work of the clinic.

Dr. McIntosh Burns was called upon to make this report. It was shown that out of every 100 adults that came to the clinic during the year 1924, 20 had been diagnosed as positive cases, and the record showed that up to date, there had been 1043 adults examined, 71 per cent of these were white and 29 per cent colored. The total number of people found to be tubercular in this group were 201. A large number of other people were still being held under observation pending diagnosis. It was reported that the negative diagnosis had been of importance in, that during the examination, some unsuspected trouble had been located and the patient placed for treatment under other suitable agencies.

Three hundred and ninety-one children had been under treatment and out of this number, 40 of them had been diagnosed as positive cases of tuberculosis. The encouraging part of this report was that great numbers of children who had been in contact with tuberculosis had been built up, strengthened and brought into such good health, that there seemed to be no indication of the development of the disease.

Following the discussion of Dr. Burns report, Dr. C. C. Aven introduced Dr. J. P. Kennedy, Health Officer of Atlanta. Dr. Kennedy was the honor guest of the Association for the evening and presented Atlanta's plans for a great Health Week sometime next May. He also enlisted the interest of the physicians in securing better facilities for the Pasteurization of milk in Atlanta.

An interesting discussion as to the use of the X-ray in diagnosis and treating of tuberculosis followed. The different members of the staff joined in this discussion and studies were made of X-ray plates that were being used in the study of particular cases.

The following members of the medical staff were present: Drs. C. C. Aven, A. M. Dimmock, Trimble Johnson, J. C. Wall, S. C. Redd, Z. S. Cowan, M. M. Burns, Willis Ragan, F. L. Bivings, D. Y. Sage, J. R. Childs, E. A. Allen, Zack Jackson, Cosby Swanson, M. B. Copeloff, C. H. Holmes, Jas. K. Fancher, M. C. Pruitt, A. H. Bunce, R. B. Ridley, Julian Buff, J. C. Blalock, J. W. Landham, F. C. Nesbitt, J. C. Birch.

## Medical Progress

With the cooperation of our associates we propose to publish under "Medical Progress" abstracts from current medical literature of general interest to the

profession. Members of the association are invited to contribute to this Department.

Anderson, W. W., Pediatrics  
Ballenger, E. G., Urology  
Block, E. B., Neurology and Psychiatry  
Clay, Grady E., Ophthalmology  
Dowman, C. E., Neuro-Surgery  
Eques, M. S., Otology, Laryngology and Rhinology  
Fitts, Jno. B., Internal Medicine  
Greene, E. H., Surgery

Hodgson, F. G., Orthopedics  
Holmes, Walter R., Gynecology and Female Urology  
Jones, Jack W., Dermatology  
Klugh, Geo. F., Clinical Pathology  
Landham, J. W., X-Ray and Radium  
Pruitt, M. C., Proctology  
Thrash, E. C., Internal Medicine  
Waits, C. E., Surgery

**FOCAL INFECTION.** An internist just returning from a two years stay in Germany reports that the German school is laying less emphasis on the relation of focal infection to systemic disturbance, than is our custom here in the States—especially Professor Czernig of Berlin is expressing such views.

**TUBERCULOSIS.** Many papers on diagnosis and treatment have been contributed in recent months, emphasis being laid on the necessity of individualizing each particular case after getting together all available data. Ringer in an article on clinical activity calls attention to the fact that it is the general symptoms which determine the degree of activity and indicates the prognosis.

A paper by Dunham and Skavlem calls attention to the fact that chronic infection of the cranial sinuses may cause a symptom complex that maybe mistaken for pulmonary tuberculosis.

Experimental work by Mayer and Wells leads them to conclude that the evidence of the favorable effect of calcium therapy in tuberculosis is lacking and that their investigations do not reveal the fact that tuberculosis produces a bodily effect of demineralization and decalcification.

In treatment interest in artificial pneumothorax continues and the method has established for itself a place in the standard treatment in properly selected cases.

**ACUTE LOBAR PNEUMONIA.** Levy in the study of the size of the heart (roentgenographically) in pneumonia states that he finds evidence of cardiac dilatation much less frequently in those cases receiving digitalis. Locke in a report of 145 cases in

the Boston City Hospital states that the value of the Type I antipneumococcus serum was confined to those in which its use was begun in the first three days of the disease.

**DIABETES MELLITUS.** The clinical literature contains many reports of the successful treatment with insulin of diabetes and acidosis, all authors emphasizing the necessity of continued accuracy of diet and care in the dosage of insulin.

**ARTERIAL HYPERTENSION.** Relative to protein in the diet and blood pressure, the concensus of opinion now appears that in treating patients with hypertension with a fair or good renal function to avoid excessive protein intake, but not to fall below the maintenance protein balance, that of one gram of protein per kilo of body weight.

**ATHLETIC HEART.** Roger Lee states that there is no clear definition of athletic heart and that there is no clinical picture of the signs and symptoms of such a condition, or of the amount of exercise necessary to be a factor. He admits an "acute heart strain" from the immediate effects of over-exertion but suggests that the use of the term athletic heart to be incorrect and vague.

J. B. FITTS.

---

### COLONIC ANESTHESIA

The statistics of 149 consecutive cases of colonic anesthesia with an ether-oil, paraldehyde mixture, are reported by Herbert Willy Meyer, New York, and Burtis F. Robbins, Salt Lake City, (Journal A. M.



A., Nov. 15, 1924). In many instances these cases were far advanced carcinomas, and were poor operative risks. In such cases Meyer and Robbins believe that colonic anesthesia is ideal. Instances which have been reported as accidents with colonic anesthesia they attribute to some error or faulty modification in technique. Post-operative pneumonia is sometimes seen; this, however, is not the result of the anesthesia but occurs in those cases in which there has been surgical intervention, in the mouth or the pharynx. The two deaths occurring in this series of cases are attributed to suffocation from the falling back of the tongue after the patients had been returned to bed. The authors emphasize that a patient who is still unconscious following colonic anesthesia should not be allowed to lie on his back, and should be watched constantly by a nurse.

---

**The Intravenous Use of Mercurochrome 220 soluble in the Treatment of Pneumonia in Children** (Freeman and Hoppe, *American Journal of Diseases of Children*, Vol. 28, No. 3.)

Freeman and Hoppe, in the Department of Pediatrics, Emory University, treated twelve cases of pneumonia, seven bronchopneumonia and five lobar in type, by intravenous injections of mercurochrome-220 soluble. Of this series two patients died. In one, death was inevitable before the drug was given. The other child, with cyanosis of unknown origin existing for several years, showed definite improvement at first but later failed to respond to treatment. In seven cases one injection was all that was required. Three cases required two injections and two cases were given three injections. The average dose was 0.005 gm. per kilogram of body weight, using a one per cent solution.

Prior to their clinical trials, dogs were given mercurochrome intravenously. One hour after injection one of these dogs was killed and the lungs removed. The tissue juices were squeezed out and one drop was

mixed with a standard loopful of a twenty-four hour culture of staphylococcus and streptococcus separately. After incubating twenty-four hours control tubes showed luxurious growths while the bacterial suspension of tissue fluids showed only a few scattered colonies. In another experiment, on plating out streptococci, cultures mixed with tissue fluids of the lungs of dogs injected with mercurochrome before death showed 29 colonies after standing 15 minutes with tissue fluids while control plates showed 54 colonies of streptococci.

Sufficient quantities of the drug to make a one per cent solution is dissolved in distilled water and filtered. The solution is not heated. Larger doses than 0.005 gm. per kilogram body weight may be given but in their experience this is seldom necessary. In most cases the systemic reaction is mild. A few hours after the injection there is often, but not always, a rise of 1 or 2 degrees of body temperature, increased peristalsis, manifested by several large stools, and discolored urine, pale pink and occasionally brilliant red stools. They have never observed any toxic symptoms from the mercury itself.

Notes of twelve cases are reported in detail with very spectacular results. From two to four hours after the injection there is usually a rapid fall in temperature, often so sharp that it simulates a crisis, occasionally resembling a very sudden lysis. The most striking results, however, are seen in the general appearance of the patient. From the desperately ill patient with a respiratory rate of about 60 a minute, who is tossing about in extreme restlessness or who lies in a stupor and makes no effort to resist, there is often a marked change within a few hours. The child appears comfortable, quiet and in such a state seen only after a crisis in pneumonia.

Wm. W. ANDERSON.

## IMPORTANT ANNOUNCEMENT

### President Coolidge Issues Proclamation Basing Duty on Barbitol and Barbitol- Sodium upon American Valuation

On November 14th, 1924, the President, following the unanimous recommendations of the United States Tariff Commission, proclaimed that "to encourage industries in the United States, and for other purposes" the duty on diethylbarbituric acid and its salts, known as Barbitol and Barbitol-Sodium in this country, and which are chemically identical with Veronal and Veronal-Sodium, be computed upon the American valuation instead of the foreign valuation.

This is the first action of the President under the flexible tariff provision approved by Congress in 1922, in which the principle of American valuation has been put into effect.

Application was made for change two years ago by The Abbott Laboratories, the only manufacturer in the United States making and marketing Barbitol and Barbitol-Sodium exclusively under the American names. After a thorough investigation by the Tariff Commission covering the comparative costs of production, in this country and abroad, the decision was unanimous that the duties then existing on Barbitol were inadequate and recommendation was made to the President for an increase.

The Abbott Laboratories have been manufacturing Barbitol continuously since 1918.

Announcement has already been made of a reduction in the price of Barbitol and Barbitol-Sodium by them to the medical profession.

### THE AMERICAN BOARD OF OTOLARYNGOLOGY

The American Board of Otolaryngology was organized in Chicago on November 10. The following constitute the board of directors: Drs. Harris P. Mosher, Boston, President; Frank R. Spencer, Boulder, Colo., vice-president; Hanau W. Loeb, St. Louis, secretary and treasurer; Thomas E. Carmony, Denver; Joseph C. Beck, Chicago;

Thomas H. Halsted, Syracuse, N. Y.; Robert C. Lynch, New Orleans; Burt R. Shurley, Detroit; Ross H. Skillern, Philadelphia; William P. Wherry, Omaha. The office of the board is at 1402 South Grand Boulevard, St. Louis, Missouri. The board comprises representatives of the five national otolaryngologic associations; the American Otological Society, The American Laryngological Association, the American Laryngological, Rhinological and Otological Society, the American Academy of Ophthalmology and the Otolaryngology and the Section of Laryngology, Otology and Rhinology of the American Medical Association. The object of the association is to elevate the standard of otolaryngology, to familiarize the public with its aims and ideals, to protect the public against unqualified practitioners, to receive applications for examination in otolaryngology, to conduct examinations of such applicants, to issue certificates of qualification in otolaryngology and to perform such duties as will advance the cause of otolaryngology. The first examination will be held at the time of the meeting of the American Medical Association.

### NEW DRUG RELEASED

The Rockefeller Institute for Medical Research has announced the release of the drug known as Tryparsamide for use in the treatment of human and animal trypanosomiasis (African sleeping sickness and mal de cadéras) and selected cases of syphilis of the central nervous system. This action is based on results reported from clinical investigations which have been in progress for several years. The drug will be manufactured by the Powers-Weightman-Rosengarten Co., of Philadelphia, and will become available through the regular trade channels about January 1, 1925. In releasing the drug for the benefit of the public, the Rockefeller Institute desires it to be known that the Institute does not share in any way in profits that may be derived from the sale of the drug and that, with the cordial cooperation of the manufacturers, provision has been made for the maintenance of a schedule of prices on as low a basis as possible.



**BOOKS RECEIVED**

**A MANUAL OF OBSTETRICS** (Second Edition, Reset,) by John Cooke Hirst, M. D., Associate in Gynecology and Obstetrics, Graduate School of Medicine, University of Pennsylvania; Associate in Obstetrics, School of Medicine, University of Pennsylvania. Second edition. Entirely reset. 551 pages with 229 illustrations. Philadelphia and London: W. B. Saunders Company, 1924. Cloth \$4.50 net.

**A TEXT BOOK OF PATHOLOGY** (Third Edition), by William G. MacCallum, M. D., Professor of Pathology and Bacteriology, Johns Hopkins University. Third Edition Thoroughly revised. Octavo volume of 1162 pages with 575 original illustrations. Philadelphia and London: W. B. Saunders Company, 1924. Cloth \$10.00 net.

**MANUAL OF PSYCHIATRY.** For the Medical Student and General Practitioner. By Paul E. Bowers, M. D., Examiner in Lunacy, State of California; Lecturer in Neuropsychiatry, Post-Graduate Medical School of the University of California, Los Angeles. Octavo volume of 365 pages. Philadelphia and London: W. B. Saunders Company, 1924. Cloth \$3.50 net.

**DISEASES OF THE HEART,** by Dr. Henri Vaquez, Professor of the Faculty of Medicine of Paris; Translated and edited by George F. Laidlaw, M. D., Associate Physician to the Fifth Avenue Hospital, New York City; Introduction by William S. Thayer, M. D., Johns Hopkins Hospital, Baltimore, Md. Octavo volume of 743 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1924. Cloth \$8.50 net.

**NEW MEDICAL FORMULARY** (The new Pocket Medical Formulary with an appendix), by William Edward Fitch, M. D., late Major Medical Reserve Corps, U. S. A., Formerly Lecturer on Surgery, Fordham University School of Medicine; Assistant Attending Gynecologist Presbyterian Hospital Dispensary; Attending physician to the Vanderbilt Clinic, College of Physicians and Surgeons, New York City, etc. Third edition, revised. F. A. Davis Company, Philadelphia.

**SAFEGUARDING CHILDREN'S NERVES,** a Handbook of Mental Health, by James J. Walsh, M. D., Ph. D., Sc. D., Professor of Physiological Psychology, Cathedral College, New York and John A. Foote, M. D., Professor of Diseases of Children, Georgetown University Medical School, Washington, D. C., with a foreword by Herbert Hoover. J. B. Lippencott Company, Philadelphia and London. Cloth \$2.00.

**GENERAL MEDICINE,** (Practical Medicine Series, 1924). Departments: Infectious Diseases and Endocrinology, George W. Weaver, M. D., Professor of Pathology, Rush Medical College; Physician in Charge, Durnad Hospital of the Chest: (Excepting the heart) Lawrason Brown, M. D., Chairman of the Medical Board, Trudeau Sanatorium, Saranac Lake, New York; Diseases of the Blood and Blood Making Organs; Diseases of the Blood-Vessels, Heart and Kidney, Robert B. Preble, A. M., M. D., Professor of Medicine, Northwestern University Medical School; Attending Physician, St. Luke's Hospital; Diseases of the Digestive System and Metabolism, Bertram W. Sippy, M. D., Professor of Medicine, Rush Medical College: Attending Physician, Presbyterian Hospital and Ralph C. Brown, B. S., M. D., Associate Professor of Medicine, Rush Medical College, Attending Physician, Presbyterian Hospital.

**BOOK REVIEWS**

**"Nutrition of Mother and Child,"** by J. B. Lippincott Co., Publishers

In this little book, written essentially for the laity, Dr. Moore in a simple and very concise manner presents the various problems of food and nutrition with particular reference to the child and mother.

In the first few chapters he touches on the theoretical aspect of the subject, but always he brings out the practical value of these theories.

A few of the common nutritional diseases are briefly discussed and the methods of prevention thoroughly explained.

His discussions of diet and hygiene during pregnancy and lactation and the tech-



nique of breast feeding in themselves make the book well worth while. Rarely has the importance of breast feeding been so clearly emphasized, nor the methods available for the establishment and development of breast milk been so carefully presented. He does not theorize on the possibilities of every mother nursing her baby, but rather gives valuable suggestions and goes into the most minute details of procedure.

Second only to his chapter on breast feeding are those devoted to the weaning and diet in infants and young children. He stressed the importance of the early use of solid foods in developing the teeth and in furnishing the necessary vitamins.

In the appendix is found a valuable list of the ordinary foods with their caloric values. The receipts which follow are excellent in the preparation of simple dishes and will undoubtedly prove of great value to the mother.

The book impresses one above all else for its great store of common sense, its simple, direct language and its fund of practical detail.

M. HINES ROBERTS, M. D.

### **Labyrinth and Equilibrium**

**Samuel Steen Maxwell, M. S. Ph. D.**

**J. B. Lippincott Co.**

The profession is to be congratulated that so finished a scholar as Dr. Maxwell has undertaken this task.

This manual is an excellent treatise on the Biology of Equilibrium and Vertigo, and the experiments are confined to the lower animals, invertebrates, and lesser vertebrates, scorpions, lizards, etc.

Extensive researches have been conducted in recent years, chiefly in Vienna and Berlin on the human labyrinth since "Ewald" first published his experiments on the semi-circular canals of animals, and the discovery of the underlying laws of the Physiology of Labyrinth.

The subject matter of this Volume has been presented in the simplest, clearest and briefest manner, and personally I am sure

the profession will profit from a careful study of the Text.

Wm. L. McDougall.

### **OBITUARY**

Dr. W. B. Sharp died suddenly at his home 251 Courtland Street, Atlanta, of an acute heart attack, Wednesday, December 10, 1924. He was born at Waleska, Georgia, 54 years ago and educated at Emory Medical College. He was a steward of the Wesley Memorial Methodist Church and had been a resident of Atlanta for the past 30 years. Dr. Sharp was a member of the Fulton County Medical Society.

Dr. Max Jackson, prominent Macon physician, died in Miami, Florida, November 18, 1924, where he had been for only a few days on a pleasure trip. The death of Dr. Jackson came as a shock to his friends. He was born December 25, 1865, in Prussia, where his parents were visiting. His father was an American citizen. He spent his boyhood in Fayetteville, N. C., and was graduated from the University of North Carolina and Columbia University. He came to Macon at the age of 25 and had practiced his profession there until the time of his death. Dr. Jackson's body was taken to New York, where the remains were cremated and laid to rest beside the ashes of his wife. Dr. C. C. Harrold, also a member of the Bibb County Society, with other friends accompanied the body to New York.

### **WANTED PHYSICIAN**

A young and up-to-date physician to take charge of a good and established practice in one of the best towns on the South, in a prosperous and progressive community. An excellent opportunity for the right kind of man. For information write to Walker Drug Co., Montezuma, Ga.

# Medical Association of Georgia

Next Annual Meeting, Atlanta, Ga., May 13, 14, 15, 1925

President, J. O. Elrod, Forsyth.

1st Vice-President, W. A. Mulherin, Augusta.

2nd Vice-President, B. H. Wagnon, Atlanta.

Secretary-Treasurer, Allen H. Bunce, Atlanta.

Business Manager Journal, M. C. Pruitt, Atlanta.

Delegate to A. M. A., (1923-1924) J. W. Palmer, Ailey.

Alternate, J. N. Brawner, Atlanta.

Delegate to A. M. A., (1924-1925) Allen H. Bunce, Atlanta.

Alternate, W. C. Lyle, Atlanta.

## Council

V. O. Harvard, Chairman -----Arabi  
Allen H. Bunce, Secretary -----Atlanta

## Councillors

1. Chas. Usher -----Savannah  
2. C. K. Sharp -----Arlington  
3. V. O. Harvard -----Arabi  
4. O. W. Roberts -----Carrollton  
5. W. C. Lyle -----Atlanta  
6. M. M. Head -----Zebulon  
7. M. M. McCord -----Rome  
8. H. M. Fullilove -----Athens  
9. C. D. Whelchel -----Gainesville  
10. S. J. Lewis -----Augusta  
11. J. W. Simmons -----Brunswick  
12. T. C. Thompson -----Vidalia

## Vice-Councillors

1. C. Thompson -----Millen  
2. R. F. Wheat -----Bainbridge  
3. J. F. Lunsford -----Preston  
4. J. A. Thrash -----Columbus  
5. W. A. Selman -----Atlanta  
6. J. M. Anderson -----Barnesville  
7. J. H. Hammond -----LaFayette  
8. J. S. Stewart, Jr. -----Athens  
9. W. J. Hutchins -----Buford  
10. H. D. Allen, Jr. -----Milledgeville  
11. A. S. M. Coleman -----Douglas  
12. J. Cox Wall -----Eastman

## Committees 1924-25

### Committee on Scientific Work

A. R. Rozar, Chairman -----Macon  
Hugh N. Page -----Augusta  
A. H. Bunce, Secretary -----Atlanta

### Committee on Public Policy and Legislation

C. W. Roberts, Chairman -----Atlanta  
J. W. Palmer -----Ailey  
W. E. McCurry -----Hartwell  
J. O. Elrod, President -----Forsyth  
A. H. Bunce, Secretary -----Atlanta

### Committee On Arrangements

E. C. Thrash, Chairman -----Atlanta  
W. L. Funkhouser -----Atlanta  
Grady E. Clay -----Atlanta  
O. D. Hall -----Atlanta  
R. C. Stephens -----Atlanta  
Allen H. Bunce, Ex-Officio -----Atlanta  
Theo. Toepel, Ex-Officio -----Atlanta

## Committee on Medical Defense

M. A. Clark, Chairman -----Macon  
E. C. Thrash -----Atlanta  
E. C. Davis -----Atlanta  
V. O. Harvard, Chairman, Council -----Arabi  
Allen H. Bunce, Secretary -----Atlanta

## Committee on Health and Public Instruction

Theo Toepel, Chairman -----Atlanta  
H. B. Neagle -----Augusta  
J. A. Thrash -----Columbus  
J. O. Elrod, President -----Forsyth  
A. H. Bunce, Secretary -----Atlanta

## Cancer Commission

J. L. Campbell, Chairman -----Atlanta  
Chas. Usher -----Savannah  
C. K. Sharp -----Arlington  
T. J. McArthur -----Cordele  
J. M. Poer -----West Point  
C. H. Willis -----Barnesville  
W. H. Lewis -----Rome  
H. M. Fullilove -----Athens  
M. B. Allen -----Hoschton  
W. W. Battey -----Augusta  
A. G. Little -----Valdosta  
T. C. Thompson -----Vidalia

## Committee on Hospitals

H. H. McGee, Chairman -----Savannah  
R. M. Harbin -----Rome  
C. Thompson -----Millen

## Committee on Necrology

R. L. Miller, Chairman -----Waynesboro  
R. F. Wheat -----Bainbridge  
Geo. B. Smith -----Rome

## Committee On National Defense

1st District, R. E. Graham -----Savannah  
2nd District, H. M. Moore -----Thomasville  
3rd District, J. C. Patterson -----Cuthbert  
4th District, W. F. Jenkins -----Columbus  
5th District, Frank K. Boland, Chairman, Atlanta  
6th District, L. M. Gable -----Griffin  
7th District, Chas. V. Wood -----Cedartown  
8th District, E. F. Griffith -----Eatonton  
9th District, J. K. Burns -----Gainesville  
10th District, F. X. Mulherin -----Augusta  
11th District, G. T. Crozier -----Valdosta  
12th District, Has not a Medical Reserve Officer.

## STATE BOARD OF MEDICAL EXAMINERS

J. W. Palmer, M.D., President, Ailey.  
 N. Peterson, M.D., Vice-President, Tifton.  
 C. T. Nolan, M.D., Sec.-Treas., Marietta.  
 H. F. McDuffie, M.D., Atlanta.  
 O. B. Walker, M.D., Bowman.

W. C. Williams, Jr., M.D., Cochran.  
 H. G. Maxey, M.D., Maxeys.  
 A. F. White, M.D., Flovilla.  
 C. M. Paine, M.D., Atlanta.  
 B. T. Wise, M.D., Plains.

Georgia reciprocates with the states named below on the basis of a diploma only if the applicant had his diploma registered prior to December, 1894. After this date applicants who desire to get Georgia license through reciprocity are required to have stood State Board Examination. After April, 1914, applicants must not have graduated from class C colleges. Georgia does not require that applicants should have practiced one year or any other length of time in the State where they received their license before they will be eligible for reciprocity. Applicants for a certificate on the basis of reciprocity must make formal application on a blank provided by the State Board of Examiners. This blank can be secured by writing to the Secretary of this Board. The fee for reciprocity is \$50.00. The fee for certifying to Georgia License of those leaving the state for reciprocity with another state is \$10.00. The State Board examinations are held in June of each year in Atlanta and Augusta and on the second Tuesday in October of each year in Atlanta in the Legislative Hall of the State Capitol.

## STATES WITH WHICH GEORGIA RECIPROCATES

Alabama	Iowa	Minnesota	New Jersey	Texas
Arkansas	Kentucky	Mississippi	North Carolina	Utah
Colorado	Kansas	Michigan	Oklahoma	Vermont
California	Louisiana	Missouri	Pennsylvania	Virginia
Dist. of Columbia	Maine	Nebraska	South Carolina	Washington State
Indiana	Maryland	New Hampshire	Tennessee	West Virginia

## GEORGIA STATE BOARD OF HEALTH

Dr. John W. Daniel, Savannah.  
 Dr. A. D. Little, Thomasville.  
 Dr. F. D. Patterson, Cuthbert.  
 Dr. J. H. McDuffie, Vice-President, Columbus.  
 Mr. Robert F. Maddox, President, Atlanta.  
 Dr. Chas. H. Richardson, Macon.  
 Dr. A. C. Shamblin, Rome.  
 Dr. W. I. Hailey, Hartwell.  
 Dr. J. C. Verner, Commerce.

Dr. John A. Rhodes, Crawfordville.  
 Dr. J. L. Walker, Waycross.  
 Dr. M. S. Brown, Fort Valley.  
 Mr. M. L. Brittain, State Superintendent of Schools, ex-officio, Atlanta.  
 Dr. Peter F. Bahnsen, State Veterinarian, ex-officio, Atlanta.  
 Dr. T. F. Abercrombie, Secretary, ex-officio, Atlanta.

## Directors of Divisions, Georgia State Board of Health

Dr. T. F. Abercrombie, Commissioner of Health and Secretary, Atlanta.  
 Dr. Joe P. Bowdoin, Division of Venereal Disease Control and Division of Child Hygiene, Atlanta.  
 Dr. Alice Moses, Division of Child Hygiene, Atlanta.  
 Dr. C. E. Waller, Division of County Health Work, Atlanta.

T. F. Sellers, Division of Laboratories, Atlanta.  
 H. C. Woodfall, Division of Sanitary Engineering and Water Analysis, Atlanta.  
 Dr. Edson W. Glidden, Superintendent State Tuberculosis Sanatorium, Alto.  
 Dr. George H. Preston, Superintendent Georgia Training School for Mental Defectives, Gracewood.  
 Dr. M. A. Fort, Director Malaria Control, Atlanta.

## COMMISSIONERS OF HEALTH (Ellis Health Law)

Dr. Sam A. Anderson, Baldwin County, Milledgeville.  
 Dr. J. D. Applewhite, Clarke County, Athens.  
 Dr. L. L. Welch, Cobb County, Marietta.  
 Dr. J. A. Johnson, Decatur County, Bainbridge.  
 Dr. Howard E. Felton, Bartow County, Cartersville.  
 Dr. Hugo Robinson, Dougherty County, Albany.

Dr. B. V. Elmore, Floyd County, Rome.  
 Dr. H. L. Akridge, Glynn County, Brunswick.  
 Dr. B. D. Blackwelder, Hall County, Gainesville.  
 Dr. O. H. Cheek, Laurens County, Dublin.  
 Dr. J. H. Hammond, Walker County, LaFayette, Ga.

Dr. G. T. Crozier, Lowndes County, Valdosta.  
 Dr. J. W. Payne, Sumter County, Americus.  
 Dr. M. E. Winchester, Thomas County, Thomasville.  
 Dr. C. S. Kinzer, Troup County, LaGrange.  
 Dr. C. O. Rainey, Mitchell County, Camilla, Ga.



# THE JOURNAL

OF THE

## MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL PROFESSION OF GEORGIA

PUBLISHED MONTHLY under direction of the Council

Volume XIV

Atlanta, Ga., February, 1925

No. 2

### Original Articles

#### THE VEGETATIVE NERVOUS SYSTEM IN HEALTH AND DISEASE\*

J. Calvin Weaver, M. D.,  
Atlanta, Ga.

Though numerous terms have been used to designate the above important classification of nerves, such terms as diffuse, sympathetic, subjective, instinctive, autonomic, vegetative, all synonymous, the two outstanding facts and thoughts surrounding this great system are first that it is independent of the control of the will and that inas-much as it subserves the functions of organic life, it must have been created for the carrying out of the law of selfpreservation, which we know as the first law of nature.

Without the ever autonomic functioning of this lower system independent of the higher organism, existence itself would be most insecure and life with all a most precarious affair for as wonderful and mysterious as the workings of the higher organism may seem, we are all, especially the psychiatrist and internist, too familiar with the appalling spectacle of the human mind being stormed in its citadel and reason being driven wholly from her seat. To eliminate the independent functioning of the lower nervous system, serious consequences would result to the end that animal life would not exist.

Though the credit of elucidating the actual plan of the sympathetic system is to be divided between the two great British physiologists, Gaskell and Langley, and though Crile and Cannon of our own country are the first exponents of the clinical bearings of the generalizations of the above physiologists, due credit must be accorded the earlier clinicians and internists, who without the aid of laboratory help and dependent on their special senses, developed a keen insight into the clinical symptoms resulting from disturbed function, and recognized a correct classification of the nervous system. In James Johnson's Essay on "Morbid Sensibility of the Stomach and Bowels," published about a century ago, we find two great classes of nerves mentioned, one in particular, the ganglionic, which regulates the functions of various vital and other organs as those of the stomach, liver, heart, etc.; while from a practical standpoint he sums up the principles of the clinical evidences of dysfunction or irritation of this regulating system by the words "if the nerves of the stomach in a state of health be capable of exciting pleasurable emotions in the mind, etc., we shall find that the same nerves when in a disordered state are equally capable of exciting the most gloomy thoughts in the mind and the most painful sensations in the body."

The development of a nervous system has been considered a rather late event in the process of evolution, that vital arrangement for the selfpreservation in such primitive

\*From Neurological Department, Emory University School of Medicine.

\*Read before the Atlanta Neurological Society, May 30, 1924.

organisms as the protozoa, depending on chemical stimuli, a process known as chemiotaxis. As a result of such stimuli, a plasmodium turns away from boiled water and creeps towards an infusion of dead leaves. A step further up the scale is the metazoa whose continuity of species depends on special germ cells instead of simple fission, until presently we find such a lowly animal as the sea-anemone endowed with a diffuse nervous system, a great fundamental change whereby it is provided with a more rapid response than the slower process of chemiotaxis. As a result of a nerve net spread throughout the substance of the animal, its surface is brought into connection with almost its whole musculature whereby a stimulation resulting from a touch in any portion of the animal will bring about a quick general contraction of the entire body. There is no special concentration but a uniform distribution throughout the body. With this arrangement each part carries within its own bounds a neuromuscular mechanism complete for its needs. In such a system the external surface acts as receptors which connect directly with the musculatures without an adjustor or central organ. Thus we see that a central organ is a feature of higher animals and a more recent development and that our sense organs did not develop in consequence of a central nervous system but vice versa, the central nervous system developed as a result of previously acquired receptors and muscles.

Though no doubt the initial purpose of such a rapid response mechanism would be selfpreservation in the struggle for existence, other arrangements must be made for perpetuation of the race, so the chemical stimulants or hormones so useful for preservation of the lower forms of life became highly specialized in the ductless glands and remained associated with the sympathetic system until the sympathetic system and the endocrine glands and the gonads formed a vital tripod for both selfpreservation and a continuity of the species. We will have occasion to see numerous instances of this relationship being reflected in health and disease, both physical and mental.

On account of the intricate mechanism of the vegetative system it is difficult to handle the subject with brevity and precision, so for the sake of brevity the anatomy will be discussed from a most practical standpoint, only the essentials being mentioned.

**ANATOMY:** In contrast to the sensory motor nervous system which serves the senses and muscles controlled by the will, we find included in the vegetative nervous system all those nerve fibres which go to the organs having smooth muscles such as intestines, blood vessels, gland ducts and skin, as well as nerve structures which exert a secretory influence upon glands; also certain striated muscles as the heart, the beginning and end of the alimentary tract, the muscles of the genital apparatus.

This main system is divided into two sub-heads—the sympathetic and the autonomic. By the sympathetic is meant the system of fibres arising from the middle and lower part of the thoracic cord and from the upper part of the lumbar cord—these ramify distally and make up the sympathetic cord. This is still further divided into two groups, the principal gangliated cords and the great prevertebral plexuses with the nerves proceeding from them. The two great gangliated cords consist of a series of ganglion united by short intervening cords; they are placed partly in front and partly on side of the vertebral column, from the base of the skull to the coccyx. Superiorly they are connected with plexuses entering the cranial cavity and inferiorly they converge on the sacrum. The ganglia in the main are about equal to the vertebra against which they lie, except in the neck which presents only three. The ganglia are connected to the spinal nerves by short filaments, rami communicantes of two kinds, white and gray. Some of the medullated fibres are continued over ganglia of the cord to enter the efferent branches; others end in the ganglia, often ascending or descending for considerable distance in the cord to reach the ganglia at a higher or lower level. A single fibre may send branches to as many as four ganglia, there-

by having a wide distribution in the sympathetic. The visceral branches of the second, third, and fourth sacral pass directly to the prevertebral plexus as do the visceral branches of the spinal accessory, vagus and glossopharyngeal, and facial, as also the short root from the ciliary ganglion of the third nerve. These latter I understand as the autonomic.

The great prevertebral plexuses are situated as the name implies, in front of the spine, and occupy the thorax, the abdomen and the pelvis. They are named the cardiac, the solar and the hypogastric plexus. They receive branches from cerebrospinal nerves and from both gangliated cords constituting centers for the visceral nerve supply. The foundation of the sympathetic is made up of very small medullated fibres which pass from certain of the cerebrospinal nerves into the cords and ganglia of the sympathetic. By adopting these smaller calibra fibres as a standard, Gaskell succeeded in showing that there were fibres with viscerel functions in the cranial and sacral nerves. These are sometimes referred to as the parasympathetic, with a cranial outflow and a sacral outflow though in this treatise they will be referred to as the autonomic. Of the cerebrospinal nerves which pass into the ganglia of the sympathetic, some terminate in arborizations around the cells of the ganglia of the sympathetic cord, others run upward or downward in the cord variable distances to pass by efferent rami to the prevertebral plexuses where they may end in the ganglia of these plexuses or perhaps may be continued on to secondary plexuses to break up in ganglia close to or in the organ supplied. The thoracic and lumbar ganglion constitute the vertebral or lateral ganglia, which are joined together by the sympathetic chain and which are united to the neighboring spinal nerves by white and gray communicating rami. These send out branches either directly to the peripheral organs or to more outlying ganglia as the solar plexus. Those that break up in ganglia close to or in the organ supplied are ganglia of the third order or terminal ganglia such as the plexuses of Auerbach and Meissner in the intestines.

It is significant that a single fibre may send branches to several ganglia with the result that the fibres in a communicating branch may have a wide distribution in the sympathetic.

The white rami communicantes pass from the spinal nerves to the sympathetic, while the gray rami pass between the sympathetic cord and all of the spinal nerves.

The visceral branches of the autonomic do not join the sympathetic but pass directly to the prevertebral plexuses. Besides the visceral branches of the sacral are also included in the visceral branches of the spinal accessory, the vagus, glossopharyngeal, facial, and the short root of the ciliary ganglia from the third nerve.

In the sympathetic are found the superior cervical ganglion, inferior cervical ganglion, ganglionic stellatum, solar plexus and the inferior mesentery ganglion. While in the autonomic we find the ciliary ganglion, the sphenopalatine ganglion, the parotid, the vagus and the pelvic visceral nerve. The sets of fibres recognized in the cervical sympathetic are the pupilo dilators, the motor fibres to the involuntary muscles of the orbit, the eyelids the vaso motor fibres of the head, the secretory fibres of the submaxillary gland, the pilo motor fibres of the face and neck, and the accelerator fibres of the heart. The largest and most important branch from the bulbar segment is the vagus which supplies the heart, bronchi, esophagus, stomach, intestines, and pancreas; while the sacral segment supplies the descending colon, the sigmoid, anus, bladder and genital apparatus.

The sacral portion gives but few branches to the viscera. The ganglia are usually four in number. The upper end of each is united to the last lumbar ganglion by a single or double interganglionic cord. The sacral nerves are composed of motor fibres to the longitudinal muscles and inhibitory fibres to the circular muscle of the rectum, motor fibres of the uterus, genital vaso dilators, the secretory fibres of the prostate; while the bladder muscle proper has both sympathetic and autonomic, the trigone being innervated by true sympathetic fibres only, as shown by Young and Wesson.



For a better appreciation of the practical and clinical application of the workings of the vegetative system in disease we must have a clear understanding of how the sympathetic outflow reaches its destination, a firm grasp of the most important localities supplied by the sympathetic, as well as the mutually supplementary bulbar-sacral or autonomic combination, an understanding of the double vegetative innervation as well as the antagonistic influences between the autonomic and the sympathetic. As to the mode of reaching its destination, the pre-ganglionic connector fibre springs from a cell in the lateral horn, passes out in the anterior root to enter the sympathetic chain by way of the white rami communicantes ending by a surface of separation or synapse around the cells in the above mentioned lateral, collateral and terminal ganglion. The lateral and collateral ganglion do not act as centers for a true reflex but rather as an axon reflex which is most likely due to an overflow. The bulbar autonomic constrictors of the pupils come by way of the third nerve and the ciliary ganglia. The fibres to the submaxillary and sublingual glands through the seventh and the chorda tympani, and the fibres to the parotid through the ninth by way of the otic ganglion, while the vagus brings fibres inhibitory to the heart and motor and secretory to the elementary tract.

For clinical purposes we must remember the following physiological facts: The autonomic supplies the ciliary body, the pupil and probably the levator palpebrum, stimulation of which causes contraction of the pupil, spasm of the ciliary body or accommodation spasm and widening of the palpebral fissure. Of lesser importance are the nerves to the lachrymal and salivary glands. The inhibitory action of the vagus slows the pulse, diminishes strength, and by diminishing the transmitting power of the nodal system between the auricle and the ventricle may cause heart block. The influence upon the respiration is familiar to all. In the upper digestive tract the vagus influences secretion, the state of motility and contraction of smooth muscles. Stimuli

increase secretion to hypersecretion with or without hyperacidity. Such stimulation may also cause turbulent gastric peristalsis or vomiting.

From a practical viewpoint we find that all sympathetic stimulation serves to prepare the body for a struggle and defense. The pupil dilates to increase perception of light, the heart beats more forcibly to supply the muscles with blood, the blood vessels in the viscera constrict, raising blood pressure and driving blood from the digestive area to the skeletal and cardiac muscles, lungs and brain; thereby inhibiting the digestive function while the sweat glands cool the body from the heat of excessive muscular effort.

In contrast to this the autonomic serves for bodily conservation: by narrowing the pupil the retina is shielded from excessive light; by slowing the heart rate, the cardiac muscles have larger periods to rest; by providing for the flow of saliva and gastric juice and tone to the alimentary canal, they allow digestion and absorption of energy yielding material. By this quiet service reserves are built up and the body fortified for times of need.

The final generalization brings out the antagonistic effect of the sympathetic and autonomic as follows: The sympathetic dilates the pupil while the autonomic contracts it; the sympathetic accelerates the heart while the autonomic slows it; the sympathetic inhibits the movements of the stomach and bowels while the autonomic increases them; the sympathetic contracts the exit from the bladder while the autonomic relaxes it.

Though fortified with the above concrete facts, as well as the assurance from Bianchi that the cerebral mantle has acquired relations with all the viscera or organs of life and that functions may be modified by stimuli which cross the threshold of consciousness, we must also study the effects of those highly specialized chemical stimuli or hormones so closely related to the sympathetic system.

As in the realm of thought every process has laws, known or unknown according to

which this must take place and as a consciousness of them is so far from being necessary to the process that we can not discover what they are except by analyzing the results it has left us, so with the vegetative nervous system every process must come in a certain way, and normal functioning is without the sphere of consciousness.

As it is an admitted fact that in modern neurology no diagnosis is complete without assigning to the sympathetic system and the internal glandular mechanism the proper role, we must consider the three groups and their secretions in the briefest possible way as a detailed consideration would lead us far afield.

In the first group are the Thymus and Pineal Glands which manifest activity only during early life, the period of evolution. These undergo involution at the age of puberty.

In the second group are the Thyroid, Pituitary and Suprarenals, normally active during life but varying in their activity in the various stages of life with a rapid wane during senescence. They act as stimulators and controllers of the glands of other groups as well as being chiefly concerned in the metabolism of the individual.

The third group or Gonads begin their activity when glands of the first group cease to functionate, thereby being inhibited by and antagonistic to them.

Thymic activity controls calcium and phosphorus metabolism, while a disturbance of the same causes fatigue, emotion, and tetanic spasms at the slightest pretext.

Thyroid activity is of the greatest importance in the economy of the individual inasmuch as it controls his adjustment to the difficulties of his environment by its close association with the adrenals and suprarenals. A break in this association causes many of the subjective disturbances of so-called neurasthenics and psychasthenics accompanied by blood pressure changes and fatigability.

Adrenalin specifically stimulates cells of the sympathetic without the interposition of nerve element. Where large blood vessels bifurcate and control of smooth muscles is

necessary, collections of chromaffin tissue are found. Through its direct action on the splanchnics the sympathetics are enhanced. Peristalsis is slowed, engorgement of large abdominal blood vessels is diminished, the pulse rate is increased as is the amount of blood sugar.

The pituitary is of the utmost importance. The active principle from the anterior lobe controls growth. The principle from the posterior lobe stimulates metabolism and increases peristalsis, while lately it has been credited with increasing the absorption of cerebrospinal fluid.

With the Gonads, besides the interference with carbohydrates metabolism from their dysfunction, we also find an irritability and instability of some women for several days preceding menstruation.

With the above facts in hand, if they are to prove of any practical benefit we must apply them to clinical manifestations of numerous forms and varieties and we will consider only the most important and most frequent manifestations resulting from dysfunction of the vegetative nervous system. Since the co-ordination and interrelation among the different spheres is so closely related, we realize that no disturbance in any one sphere can take place without a concomitant change occurring in the others.

While we are seeing daily references to such clinical entities as "Neurogenic Irregularities of the Heart," "Spasmodic Diplopia," "Asthma of Neurogenic Origin," and different forms of "Glycosuria," "Reflex Dyspepsia," "Appendix Dyspepsia," "Spasmodic Stricture," and innumerable others, all of a functional nature, the great general functional disorder as worked out by Eppinger and Hess, we know as Vagotonia

To use their own words "By vagotonia we understand a lasting, tonic irritation in the realm of the autonomic system which maintains its end organs in a state which very closely resembles that produced by electrical stimulation of the autonomic." Thus we may say that vagotonia is a purely functional disease, not referable to any organic base, which does not affect one organ alone but spreads out in several branches

until it finally involves them all and affects the entire autonomic system.

Under vagotonia we find two main headings or classifications: (1) General Vagotonia and (2) Local Vagotonia.

By way of recognition of the chain of symptoms indicative of a departure from the normal, the vagotonics, practically the same picture as referred to by Gehring in his "Hope of the Variant" as ill health in functional form—we note the following manifestations referred to the various organs.

**EYE AND EAR:** Hyslop reports seven cases that he described as spasmodic diplopia. Ruling out such organic causes as encephalitis, basal meningitis, pontile tumors, vascular brain lesions, and various other causes, he reaches the conclusion that this transitory diplopia resulted from overactive vagus function, as there was no relation to use of the eyes.

Mention is made of paresis of accommodation during convalescence from severe febrile attacks with the suggestion that the condition results from irritation of the autonomic system.

Friedrich has observed that an acute myosis is almost a typical symptom of gastric crisis.

As a practical illustration of the far reaching effects of the morbid reflex one of my patients who was suffering the most aggravated symptoms of chronic prostatitis, with the most morbid nervous manifestations, though relieved of practically all of his symptoms, still has attacks of burning of his eyes that is instantly relieved by massage of the prostate. Allow me to mention another case of chronic prostatitis showed a tinnitus of his left ear which proved a veritable barometer as to the indication for treatment. Massage of the prostate gave instant relief, which lasted for three or four days. With relief from the prostatic condition and the gradually clearing up of his nervous symptoms the tinnitus entirely disappeared.

Biehl, in his article on vagotonia relates several cases of tinnitus in which the symptom was relieved by drugs depressing the peripheral portion of the autonomic, with the conclusion that tinnitus may at times be regarded as evidence of vagotonia and is of vasomotor origin.

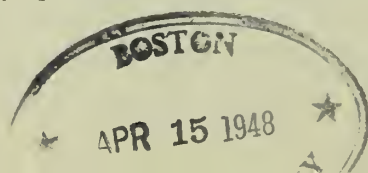
Not infrequently, a mild spasm of convergence or a kind of convergent strabismus has been noticed as has also epiphora or an overflow of tears.

**SALIVARY GLANDS:** It is claimed that salivation is a result of a state of autonomic stimulation of the salivary glands. Increased salivation is not unusual among the nervous. In contrast to this, the antagonistic action of the sympathetic on the secretion is clearly demonstrable in inhibition of salivary secretion. This action is well demonstrated in the dry mouth of fear and was the basis of the old Indian rice "ordeal" in which persons suspected of crime were given consecrated rice to chew. The man who spat it out dry was adjudged guilty.

**SKIN:** Sweating which assumes pathological proportions is considered a symptom of vagotonia. Attacks of sweating result from conditions associated with increased vagal tonus as nausea, asthma, acute indigestion and angina pectoris.

Occasionally we encounter patients with circumscribed areas involved as hands, feet or head. The functionally nervous usually always have moist and cold hands and feet. Observation has been made that skin which is sweating profusely will not show dermographism.

**HEART:** In the list of neurogenic irregularities of the heart, we find fluctuation in the activity of the sino-atrial node in children, an expression of instability of the incompletely developed nervous mechanism of the heart. Sinus irregularity in adults, which according to McKenzie means a healthy heart, though claimed by Eppinger





and Hess as an evidence of vagotonia. Sinus activity results from two oppositely acting sources of innervation and the variation may be one of four possibilities: an increase or diminution of vagal tone; or an increase or diminution of sympathetic tone.

Of the bradycardias, those in young people are a certain sign of vagal stimulation. Of this type are those occurring as a result of bile stasis in jaundice, the retained salts affecting the vagus. The type best known is that resulting from intracranial pressure, as in cases of brain tumor, hydrocephalus, etc. These forms are referable to cerebral stimulation of the vagus.

We are all familiar with cardiac disturbances arising from the alimentary tract, while it seems a well grounded fact that reflex accelerator stimulation may be emotional or result from stimulation of sympathetic nerves. Patients with sinus arrhythmia due to vagotonia suffer from hyperacidity and spastic constipation, with the other classical symptoms.

In these irregularities it is important to determine the source of abnormal stimulation, the most important source of afferent impulse being the heart and aorta. From a surgical viewpoint we find that cervical sympathectomy sometimes relieves attacks of angina pectoris, and that the pain resulting from calcified arteries of the leg is relieved by carefully stripping the sheath with its sympathetic fibres. Jonnesco, the pioneer, in resection of the sympathetic regards angina as a manifestation of irritation of the cardioaortic plexus, in fact a neuralgia of it, and recommends the sympathectomy in these angio spastic conditions.

Though De Schweinitz reports that sympathectomy causes myosis, narrowing of the palpebral aperture, retraction of the globe, diminished intraocular tension, he notes that eventually these become gradually less marked and may disappear.

During the late war a new nerve disorder was described as reflex paralyses. Bashinski, J., proposed the term physiopathic, a term intended to express the idea that on

the one hand neither hysteria nor any other psychopathic state can produce them, and on the other hand that while indicating a physical and material disorder of the nervous system, they do not appear to correspond to any lesion which can be detected by the methods at our disposal." Recently hope has been held out that spastic paralysis will be cured by severing the white rami communicantes of the parts involved.

The most dangerous heart condition due to vagal irritation is a disturbance in the transmission of cardiac impulses, which we know as heart block. This does not imply complete interruption of impulses from auricle to ventricle but a condition in which several auricular impulses occur before one finds its way through to the heart.

**DIGESTIVE APPARATUS:** The functional disturbances of the digestive apparatus resemble so many organic troubles that many years ago they were aptly designated "Mimoses" or imitators.

Among the reflexes associated with the organs of digestion are such manifestations as reflex dyspepsia, pancreatitis, enteralgia appendix dyspepsia, atonic dilatation, hyperchlorhydria, etc., as well as reflex asthma. It is not difficult to see the possibility of gastrointestinal reflex asthma as embryologically the lungs are formed from a diverticulum from the intestines, resulting in a close association between respiratory and digestive tract innervation.

By way of generalization of the effect of morbid reflexes generally, we quote again from Johnson's Essay as follows:

"There is no effect of indigestion more common than dejection of the mind. The amount of suffering which is inflicted on the body through the agency of the mind is only equalled by the retributive misery reflected on the mind through the medium of the body.

"There is but one part along which these reflexes can travel from the organ of

thought or higher organism to the organs of digestion but the number of airy sprites and the velocity with which they glide along the silvery pneumogastric conductors baffles all calculation."

As it seems probable that in the mad rush of civilization, the variants or nervously ill will rapidly increase as time goes on, the play of affinities and reciprocity of sympathies between the intellectual and material portions of our natures must be more closely attended to if we are to prevent the structural or organic changes resulting from prolonged interference with perfect functioning.

As man is a subconscious creature first, advantage must be taken of training (which deals with the instinctive) in the formative stage of youth. It may begin the day of birth.

By persistent, intelligent patience, this training will gradually beat down a broad pathway through the nervous network that will mean helpful habits that will last throughout life. Later, by an appeal to understanding or teaching, the variant can be reshaped and stimulated to grow in whatever direction he appears defective and controlled wherein he is excessive.

We must all appreciate fully the unity of the human organism and know that no disease is limited to a given organ.

The neurologist must develop an interest in disturbances in that portion of the nervous system presiding over organic function. The pediatrician must go still deeper into dysfunctions of the endocrin system. The surgeon must recognize more and more functional disturbances so as to avoid post-operative morbidities, while the internist must give more thought to visceral neurology. The neuro-physiologists must give intense study to the relationships between the vegetative nervous system and the endocrin secretions with their effects on health and disease, until they are sufficiently understood to be the common property of the entire medical profession.

In this broadened sense neurology will

ultimately assert itself as the basis upon which the future structure of medicine may be built.

In the meantime let us not be unmindful of the Divine Afflatus at the core of our beings, with the limitless power to vary upward as well as downward, nor forgetful of the eternal spirit within which gives us latitude wherein to save ourselves.

#### GENERAL REFERENCES

1. Wedd: Neurogenic Irregularities of the Heart in Adults. American Journal of the Medical Sciences. CLVII. No. 1.
2. Eppinger and Hess: Vagotonia. Nervous and Mental Disease Publishing Company, New York, 1917.
3. Langdon Brown: The Sympathetic Nervous System in Disease. Oxford Medical Publications.
4. Thomson: Outlines of the Laws of Thought. Sheldon and Company, New York.
5. Pottenger: Asthma Considered in its Relationship to the Vegetative Nervous System. American Journal of the Medical Sciences. CLV. No. 3.
6. Pottenger: The Importance of the Vegetative Nervous Systems. Nervous and Endocrin, to Clinical Medicine. Reprint.
7. Quain: Elements of Anatomy. Vol. III. Part II.
8. James Johnson: An Essay on Morbid Sensibility of the Stomach and Bowels. 1828.
9. Halstead and Christopher: Cervical Sympathetomy for Angina Pectoris. Journal of the American Medical Association. Vol. 82. No. 21.
10. Hyslop: Spasmodic Diplopia. Vol. 82. No. 15.
11. Young and Wesson: The Anatomy and Surgery of the Trigone. Archives of Surgery. July, 1921.
12. Gehring: Hope of the Variant.
13. Bianchi: The Mechanism of the Brain and the Function of the Frontal Lobe. Wm. Wood and Company.
14. The Evolution of Man. Yale University Press.

#### TWO CASES OF AMYOTONIA CON- GENITA OCCURRING IN THE SAME FAMILY

The two cases reported by Gerald R. Allen, Rockford, Ill., (Journal A. M. A., Sept. 13, 1924), are of interest owing to the fact that heredity, or a familial tendency, has not been noted in the cases heretofore reported. These cases, and possibly a third, all occurred in male children in the same family, whereas, two female children in the family showed no signs of the disease.

## FREQUENTLY OVERLOOKED CONDITIONS OF THE URINARY TRACT\*

C. D. Whelchel, M. D.,

Gainesville, Ga.

It isn't the object of this paper to bring before you anything new, but to call attention to some of the more common conditions and diseases of the urinary tract other than nephritis, and the important role played by them in our general economy.

We were taught by Israel years ago before the advent of X-ray that the most important thing to learn in the diagnosis of Renal or Urethral Calculi was to unlearn the picture put forth by most text books. The old time fallacy that a stone must spill blood in its wake has been exploded by Braasch and Moore of the Mayo Clinic, who have shown the absence of blood in more than twenty per cent of cases. The X-ray is by no means always perfect, depending upon the content of the stone. Calcium stones almost always show, while those of urates and uric acid do not always show. Again a small stone may lie immediately over a bone, especially is this true near the brim of the pelvis where bony wall shadows exclude them.

The kidneys are organs of excretion, the anatomy and physiology of which I am sure you are perfectly familiar. Are surgical conditions of the urinary tract becoming more frequent or, are we beginning to recognize them as we have never before done? Not until instrument of precision requiring special skill for their manipulation and experience for their correct interpretation of findings make it possible for us to study and recognize conditions heretofore overlooked.

**Kidney stone:** One of the most common, best known and most suggestive symptoms of stone in the kidney is the sharp lancinating pain which has been called kidney colic. This picture I am sure is perfectly familiar to you all, however, all such cases do not have kidney stone, but may have some one of the conditions of which we will speak

later. Kidney stone is not, in every case, associated with pain or any other constant symptoms. One case which came under my observation was an apparently healthy man of about 26 years of age, who applied for Life Insurance, and stood an excellent examination until his urine was examined, which showed albumen, microscopic examination showed R. B. C. and pus cells. This patient was referred to us to find the origin of these evidences of pathology. Cystoscopic examination of bladder was negative, ureteral catheterization showed blood and pus coming from the kidney. X-ray examination showed a stone about the size of a quail's egg. This patient had never had a pain of any nature in region of either kidney. Most of these stones produce symptoms, the most common being pain of colic nature, which begins in the groin and radiates down the course of the ureter to the external genitalia and down the thighs.

Some patients will have symptoms which seem typical of kidney stone, however, most of them will complain of pain which is paroxysmal in character, starting over one or the other kidney and radiating down the course of the ureter, or remaining localized in the kidney region. Others will only complain of dull pain in lumbar region, abdominal pain, or pain referable to bladder. A common complaint is frequent desire to urinate.

**Pyelitis:** An inflammation of the pelvis of the kidney which may be acute or chronic, occurring at all ages from less than a week old to the aged, but most commonly seen in early middle life.

**Predisposing causes:**

Diseases of G. I. tract of which constipation is foremost.

Diseases of Rectum and Anus—as fistula, fissure and hemorrhoids.

Lesions of G. U. tract as vesiculitis, prostatitis, hydronephrosis and stricture of ureter.

Diseases of the female generative tract, especially pus tubes, uterine infections or any pelvic inflammation.

Sex plays some part as a predisposing cause as shown by Kretschner. 39 per cent

\*Read before the Ninth District Medical Society, Gainesville, Ga., Sept. 17, 1924.



of his cases being males and 61 per cent females. The greater number occurring in females is due to the different anatomy, and the more liable are females to diseases of the G. U. tract. Also females suffer from constipation more frequently than males. It is believed by Francke that there is a direct communication between the large bowel and kidney on right side and probably on the left. Starr says the lymphatics of kidney capsule communicate with the deep lymphatics of the kidney.

**Ureteral stricture:** Clinical evidence has shown that stricture of the ureter often results in dilatation of the tract above the point of stricture with more or less infection and damage to the kidney substance.

**Pregnancy:** Pyelitis of pregnancy is a much more frequent condition than thought to be, owing to the fact that many cases are overlooked because insufficient importance is attached to the urinary symptoms of which many pregnant women complain, also the neglected microscopic examination of urine and little significance attached to the finding of pus. The principal role played by pregnancy as an etiological factor is thought to be due to pressure on the ureters by the enlarged uterus. Dr. DeLee says "It does not seem to me unlikely that, regardless of pregnancy, almost every woman has had pyelitis at some time during her life."

**Symptoms:** Pain on affected side, or abdominal pain, frequency of urination, burning and painful urination, turbidity of urine, difficult urination, nausea, vomiting, sweats and fever. How misleading the pain is sometimes is well shown in the following case report. A married woman, about 31, was rushed to the hospital from an adjoining town for immediate operation. The pain she suffered was colic, most severe in region of appendix. She was nauseated and had been vomiting. Leuco. 15600. Temp'r. 99.3. In spite of this picture we hesitated to open her abdomen, but had her prepared and sent to operating room for operation—here we backed out and would not operate until her right kidney had been

catheterized, which was done, showing an abundance of pus. The left kidney was then catheterized which showed an equal amount of pus, here we were dealing with a double pyelitis and not an acute surgical abdomen.

Treatment of Pyelitis may be considered under three heads: 1st, Vaccine Therapy. 2nd, Medical Treatment. 3rd, Pelvic Lavage. Vaccine Therapy should be considered under two types—Stock Vaccine and Autogenous Vaccines. In my hands, neither have been very useful. One patient now under my care has been through a long thorough treatment of Autogenous Vaccine Therapy without any apparent improvement.

Medicinal treatments are very useful in many cases but cannot be relied upon. Pelvic lavage, in our hands, has offered the best and most lasting results. We use two per cent silver nitrate in pelvis of the kidney—repeated dosage upon urine examination.

**Ureters—**The kidney and bladder have received more consideration than the tube connecting them. It is urged that the ureters be more carefully examined, for such examinations and study will often clear up obscure symptoms which have embarrassed us all. We should study the ureters more carefully in order to learn the pathologic changes and consequent symptoms.

Let us briefly consider these organs: They are about 29-30 c. m. long, 5 m. m. in diameter and more or less flattened when empty, their caliber not being uniform as there are four physiological constrictions: (1) just below the renal pelvis (2) crossing the iliac vessels (3) passing through the broad ligaments in females (4) in the wall of the bladder. Any one of these physiological constructions may become narrowed and result in a pathological constriction.

The ureter is composed of three coats, outer fibrous, middle muscular, inner mucosa. Blood supply is from renal, ovarian in female, and spermatic in male, and vesicular.

**Relations:** It is loosely attached and suspended from the kidney by retro-peritoneum.

They only have an approximate course being outside of a line that marks the traverse process of the lumbar vertebrae. The course depends largely upon the position of the kidney. I saw one pelvic kidney which showed the course of the ureter following closely the brim of the pelvis for a semi-circle, however, in the normal position it passes directly under the head of the caecum near the base of the appendix.

Stones in the ureter and ureteral stricture are of the greatest sources of error in right side pain. Such pain in right iliac fossa associated with nausea, vomiting and more or less rigidity is frequently mistaken for appendicitis.

We had a patient sent to hospital from an adjoining town for operation for appendicitis, a mass was readily felt in right side but too high for appendiceal abscess, he had been in pain about twenty-four hours and without sleep, he gave a history of having an attack like this about twelve years ago, which gradually subsided in about ten days. There was nausea, vomiting, muscular rigidity, and fever. Upon X-ray examination a mass was found in right kidney.

Here we decided to catheterize this kidney before operation. The cystoscope passed readily, bladder apparently normal. The right ureter a little patulous and reddened, left normal. The right catheter met obstruction at about the brim of pelvis, however it passed with a resulting stream of urine through a number 6 catheter. In about five minutes patient was asleep and slept for more than 18 hours. I should here say he had had  $\frac{3}{4}$  grains of morphine before coming to hospital. Patient left hospital the following day without pain, however some soreness. The diagnosis here was Hydro-Nephrosis. The capacity of kidney, pelvis and ureter was 180 c. c.

Diagnosis: The diagnostic value of thorough urinalysis can not be over estimated, and ordinary drop specimen taken at random may not yield any information, but the repeated careful examination will show occasionally some blood or pus, or both, which is of diagnostic aid, however, it must be constantly in mind that blood

and pus in the urine mean nothing to you unless you know its exact origin, as it may originate anywhere from the cortex of the kidney to the external opening of the ureter and vagina in females. Pyuria and hematuria are symptoms of T. B. of the entire urinary tract, renal or ureteral calculus, urethritis, cystitis and vaginitis. Our only source of differential diagnosis lies in the ureteral catheter and X-ray. Here we are forced to differentiate pyelitis, renal and ureteral calculus, T. B. of G. U. tract and pyo-nephrosis; with good X-ray technic stones can usually be excluded. T. B. can be excluded by direct smear examination and guinea pig inoculation. Ureteral stricture, hydro-nephrosis and tumors can be excluded by X-ray.

Treatments of stones in kidney and ureter depend upon (1) size of stone, (2) number of stones, (3) location, whether or not impacted.

About 25 per cent of small stones will pass unaided in first three months, a large number of stones will pass by the introduction of a ureteral catheter, many will pass after dilatation of ureter and introduction of some substance as olive oil, which acts as a lubricant and a dilator if introduced under pressure, which must be small.

Indications for surgical intervention are when you have large stones that can't possibly pass, when there are several stones, when the stone is impacted and can't be dislodged, and where non-operative treatment has failed.

The treatment of pyelitis we have referred to above. Treatment of stricture of the ureter: Dilatation of the stricture, with the establishment of free drainage.

---

### ATYPICAL MUMPS

The case reported by William L. Gould, Albany, N. Y. (Journal A. M. A., Sept. 13, 1924), is atypical and unusual in that but one parotid gland was attacked, with a complicating metastasis to almost the whole of the same side of the body, the opposite side remaining entirely free.



# EXTERNAL PACHYMENINGITIS SIMULATING PURULENT LEPTOMENINGITIS\*

## Report of Case

William L. McDougall, M. D.,  
Atlanta, Ga.

Recovery from meningitis developing secondary to otitic infections is fairly rare, and justifies the reporting of this case.

The differential diagnosis between external pachymeningitis and purulent leptomeningitis secondary to extra dural abscess as outlined in the majority of text books gives little difficulty. However, in actual practice, in certain cases, one finds it difficult to make a correct diagnosis.

The correct diagnosis depends on careful and repeated examinations of the cerebro-spinal fluid.

Meningeal involvement of otitic origin has been classified into 5 types, namely; (1) Purulent inflammation of the external surface of the brain with the formation of extra dural abscess. (External Pachymeningitis). (2) Internal Pachymeningitis. (3) Purulent Lepto-Meningitis. (4) General Meningitis, and (5) Tubercular Meningitis.

Purulent lepto-meningitis occurs at all ages, but rare in infancy and childhood. The meningeal involvement usually begins at the point of contact of the dura and the diseased bone, and spreads from this point, however this is not always true. The pus spreads along the base of the brain overlying the tegmen tympani and along the inner table of the mastoid process, according to the origin of the infection.

The onset of the disease is sudden and usually accompanied by spontaneous nystagmus toward the diseased ear, if the infection passed through the labyrinth, and internal auditory meatus to the posterior fossa.

Headache, nausea, vomiting, marked elevation of temperature, flushed face, pulse ranging from 120-150, respirations rapid and shallow, mental irritability, delirium, and extreme restlessness, rigors are usually present, pupils usually contracted on the affected side, choked disc, optic neuritis, papillitis,

muscles of the face contracted, and the head retracted with spinal involvement, shown by increased tendon reflexes, parasthesia and hyperesthesia of the extremities, are common symptoms.

By lumbar puncture we find increased pressure, cloudy fluid, increased coagulability, and the presence of bacteria.

The course of the disease is rapid and short. The prognosis is grave, death occurring in nearly every case.

External pachymeningitis is the most frequent otitic intra-cranial complication following acute mastoiditis, and the usual site is the middle cranial fossa over the tegmen antri or tympani. The dura is usually discolored, thickened, and covered with granulations. Many of the symptoms as outlined above are common to this type of meningitis. In the following case the clinical picture resembles almost exactly that of a case of purulent lepto-meningitis. The course of the disease varies somewhat, with severe symptoms, the termination may be rapid and fatal, however, recovery is probable if the disease extends over a period of several weeks.

Lumbar puncture is our greatest asset as to diagnosis, and to treatment, and the diagnosis depends on repeated and careful examinations of the cerebro-spinal fluid.

Regarding the treatment, spinal drainage in some form is our only hope, and it is no novel in the treatment of meningitis, it has been used for the past fifty years in one form or another.

The chief drainage routes are: (1) Lumbar puncture; (2) cisterna magna; (3) ventricular puncture; (4) cortical sub-arachnoid puncture; (5) laminectomy in the lumbar region with continuous drainage.

Regardless of the site chosen, drainage should be instituted early in the disease and continued until the cerebro-spinal fluid is declared normal by the laboratory, and all symptoms of meningeal irritation have subsided.

## Report of Case

J. W., a colored male, age 23, was admitted to Grady Hospital, January 29, 1924,

\*Department of Otolaryngology, Emory University School of Medicine, Atlanta, Ga.



complaining of sore throat for the past five days. His family history was negative. His past history was negative to ear diseases. He had typhoid fever at the age of eight, influenza at fifteen with no bad after effects. Has had an occasional sore throat for the past three years.

Present illness began January 24, with a sharp pain in the right shoulder which disappeared the same day. On the following day his throat became extremely sore, and was especially painful on swallowing. The next day a throbbing pain was felt in the left ear, followed two days later by a spontaneous rupture of the left tympanic membrane, with a small amount of purulent discharge coming from the left ear.

Physical Examination: Both tonsils acutely inflamed and markedly hypertrophied, with large crypts, and a large amount of pus was expressed on pressure.

There was a slight purulent discharge in the left canal, the tympanic membrane was perforated in the posterior-inferior quadrant, and the discharge was pulsating through the opening in the membrane. The tympanic membrane was moderately thickened and intensely reddened, particularly in Shrapnells' area. Pressure elicited slight pain over the tip of the mastoid bone, but no pain over the antrum or emissary vein. There was a slight cellular edema over the left temporal region, just over the auricle, which was tender to touch. There was no spontaneous nystagmus present. The superior canal wall was definitely sagging. Both labyrinths were active. There was marked impairment of hearing on the left ear by air conduction, and a moderate increase in bone conduction. The right ear was normal. The temperature was 102°, the pulse 108 and respiration 22. Culture from the tonsils revealed hemolytic streptococci; the smear from the left ear showed streptococci, and the culture from the left ear showed hemolytic streptococci. The white cell count was 18,700. The chest was negative; urinalysis negative; blood culture negative. The X-ray of the left mastoid showed an acute inflammation of the mastoid cells, with a complete loss of cell outline.

On January 30, the following day, there was no change, the temperature, pulse, and respiration remaining the same.

- On January 31, the patient complained of headache in the left temporal region, the temperature was 101°, pulse 110, and respiration 20. On February 1, the temperature rose to 102°, pulse 116, and respiration 24. A simple mastoidectomy was done, all the mastoid cells were broken down and filled with pus and granulations throughout. An extradural abscess the size of a five cent piece was revealed in the middle fossa, the dura was discolored, muchly thickened, and covered with dirty grayish-black granulations. The unhealthy and necrotic bone around the abscess was removed until healthy dura appeared. The entire mastoid was exenterated of all diseased bone and granulations, the aditus ad antrum opened wide, and the wound packed lightly with iodoform gauze, and left wide open.

Course: On admission, January 29, the temperature was 102°, pulse 108, and respiration 22. On the day of operation, February 1, the temperature was 102°, pulse 116, and respiration 24. The day following operation the temperature dropped to 99°, and the second day afterwards rose to 103°, and then gradually returned to normal on the fifth day, when it suddenly rose to 105°, with a slight chill.

The chest was examined and found to be negative; urinalysis negative; blood culture negative; lumbar puncture revealed hazy fluid, under moderately increased pressure, with 80 cells per c. m. m. The white cell count was 10,850.

On February 7, the next day the temperature dropped to 99°. The wound was dressed daily and was in good condition with free drainage, and the patient felt fairly comfortable.

On February 10, the patient complained of a dull headache in the left temporal region, and a general muscular tonus increase with tremors was noticed. The entire left side of his face did not respond to voluntary movements or to emotional activity, denoting a facial paralysis. A neurological

examination revealed irregular and hyperactive reflexes, definite ankle clonus on both sides, pupils both dilated and did not react to light or accommodation.

Examination of the ocular fundi showed: Right, normal; left, veins tortuous and slightly fuller than right.

There was an area of tenderness over the renal region, and paralysis of the muscles of the left side of the face. Impression meningitis, and facial paralysis left side.

On February 8, examination of the ocular fundi revealed normal right fundus, and the left about the same as on previous examination except the veins were slightly more distended, and an exposure keratitis was developing on the left cornea.

A spinal puncture showed cloudy fluid, under considerable pressure, with a total cell count of 80, with 80 per cent polymorphonuclear leucocytes, and 20 per cent small lymphocytes. A gram stain was made from the fluid and 6 or 7 short chain streptococci found. Culture showed no growth. Globulins 4 plus. Sugar negative. A smear from the wound showed streptococci and a culture from the wound showed hemolytic streptococci. The chest was negative and the urinalysis negative. On the following day there was moderate rigidity of the neck, a positive Kernig bilateral; positive Babinski on the left side. The patient was irritable and complained of headache, dull in character over the entire left side of the head. There was no nausea and no vomiting, the patient refused to eat, and complained of feeling chilly. The temperature was 103°.

During the next five days there were excursions and remissions of temperature from 1 to 4 degrees, the pulse remaining around 110 to 114, and the respiration around 22-24.

From 20 to 25 c. c. of spinal fluid was removed daily by cisterna magna or lumbar puncture. The cells gradually increased daily up to 4,290 per c. m. m., on the 23rd day after operation, an increase in polymorphonuclears over the small lymphocytes occurring daily. Daily cultures of the cerebro-spinal fluid were negative, however, on several occasions smears showed short

chain streptococci. On the 17th after operation the temperature dropped to 99, the spinal cell count began a gradual decline from 4,290 to 180 on the 32nd day. During the entire course the leucocytes varied between 10,850 and 18,750 with a polymorphonuclear leucocytosis prevailing. The spinal fluid was cultured daily for the first 10 days and every second day thereafter, and each time no growth was obtained.

On the 35th day after operation the temperature rose to 103° and a typical small pox eruption appeared upon the hands and face of the patient and he was transferred to the Contagious Hospital where the treatment was continued. Daily, or every second day, cisterna magna or lumbar punctures were done until the fluid was clear, under no increased pressure, negative for globulins, positive for sugar, and the cell count down to 12 per c. m. m. The wound was allowed to close and the patient left the hospital on the 49th day after operation, making a complete recovery. Since that time he has pursued his usual duties, and the facial paralysis had when I last saw him practically cleared up, being hardly perceptible.

### Summary and Conclusion

The differential diagnosis in the case depended on repeated and careful examinations of the cerebro-spinal fluid. The patient exhibited typical symptoms of Purulent Lepto-Meningitis. In spite of the fact that on several occasions we were able to find five or six short chain streptococci in the spinal fluid by smear, and in view of the fact that repeated cultures of the spinal fluid failed to show a positive culture we are justified in making a diagnosis of External Pachymeningitis.

---

### BOOK RECEIVED

REPORT OF THE SCIENTIFIC RESEARCHES ON THE VENERAL DISEASES, prepared by Edward L. Keyes, presents results of scientific investigations on venereal disease problems financed by the Federal Government and the American Social Hygiene Association.



**PLEURAL EFFUSION\*****Champ H. Holmes, M. D.,****Atlanta, Ga.**

My principle object in addressing you upon a subject so well known and familiar as pleural effusion, is to emphasize again the association of this condition, with pulmonary tuberculosis. This association is not only important from an etiological concept; but because it imposes upon one the intelligent after management of the case. Idiopathic or primary pleurisies were formerly regarded as frequent; but now it is rapidly being acknowledged, that in most instances they are tuberculous, and as a rule secondary to disease in the lungs or bronchial lymph nodes. Dr. Joseph Capps, professor of medicine at Rush, states that 70 to 80 per cent of all serous pleural effusions of any appreciable size are tuberculous. In every pleural effusion, with no demonstrable cause, consider it tuberculous, until the contrary is proven. In an insidiously developing serous or sero-fibrinous effusion with little or no symptoms, the probability of it being tuberculous, is almost a certainty. In its relationship to pulmonary tuberculosis, both as to etiology and as a mode of onset, a primary pleurisy is closely analogous to hemoptysis. Pleural effusion, though while it does occur during the course of clinical pulmonary disease, it more often precedes it. Dr. Brown, at Saranac Lake includes a positive history of pleural effusion as one of the cardinal points in the diagnosis of pulmonary tuberculosis. Taking a careful history on a large number of tuberculous patients, how frequent indeed, is a history of "water on the lung," anywhere from one to fifteen years previously, obtained. Statistics on several large series of cases, averaged an incidence of 37 per cent.

An interesting concept of serous membrane tuberculosis is that of hypersensitivity. According to this theory, the individual is hyper-sensitive to a focus of tuberculosis within the body and on coming in contact with a small dose of tubercle bacilli, the

serous membrane responds by pouring out serum, cellular elements and fibrin. Guinea pig experimentation goes to substantiate this theory. After injection of a small dose of tubercle bacilli in a guinea pig already sensitized by a previous dose, there is a stormy reaction, quite different from the first, in which the serous membranes pour out an exudate.

Other than tuberculosis, there are numerous pathological states which may give rise to a pleural effusion, chief among these are the pneumonias and other inflammatory processes, within the thorax. Bacteriologically the organisms most often encountered in effusions are the tubercle bacillus, pneumococcus and the streptococcus.

The fluid in effusions is an exudate, in contrast to a transudate as seen in some cardiac and renal conditions. An exudate and a transudate can be more or less satisfactorily differentiated in most cases by an examination of the fluid. The transudate is clear; low specific gravity, 1.010 to 1.015; poor in protein, less than 30 grams, per litre; contains few cells, chiefly endothelial and lymphocytes, and with few or no organisms. An exudate being inflammatory in origin, may be serous, sero-fibrinous, sero-purulent, purulent or hemorrhagic; specific gravity of over 1.015; rich in protein, over 40 grams per litre; contains many cellular elements, fibrin, and in some cases numerous organisms. A hemorrhagic effusion is strongly suggestive of tuberculosis or malignancy. In young children under three years, the effusion is nearly always purulent, and in fact a serous effusion is relatively infrequent below the age of ten.

The onset of pleural effusion and its subsequent course varies and largely depends on the underlying pathology. The onset may be acute with a chill; fever, 100 to 103; pain in the side; slight cough, and rapid pulse; or it may develop insidiously and the patient presents himself complaining of slight shortness of breath, and examination reveals a massive effusion.

Time does not permit me to go in detail into the physical findings in pleural effusion, so I will suffice with just mentioning

\*Read before the Fulton County Medical Society, May 15, 1924.



the usual ones, namely:—obliterated interspaces, lagging or absent expansion on the affected side; dullness to flatness with increased resistance on the affected side; dislocation of heart and trachea toward the sound side; suppressed or absent fremitus over the effusion; suppressed or absent breath sounds over the effusion; Skodaic resonance and aegophony above the level of the fluid; movable dullness; Grocco's paravertebral triangle of dullness; Garland's triangular area of hyper-resonance over the relaxed lung; the S-shaped line of Ellis crossing the axilla; Bacelli's sign dealing with transmission of the whispered voice; downward displacement of liver; and signs of sympathetic stimulation on affected side, such as unilateral sweating and dilated pupil. Rales may or may not be present. Here, as in other conditions, many of the signs may be absent; and some of those present, atypical. The amount of fluid, the degree of lung compression, adhesions and underlying pathology may considerably alter the findings. The small effusion is frequently overlooked, and Dr. Osler is quoted as having stated that in his consultation practice, an overlooked effusion is his most frequent finding. Experimentally, 400 cc. in an adult and 120 cc. in a child, will give physical signs. In infants and young children the signs are very variable, and in them I think percussion is the most valuable. Many a child has died from empyema, because the intense bronchial breathing was attributed to a pneumonic consolidation. Thoracentesis is a comparatively harmless procedure and should always be instituted where fluid is suspected.

The treatment of a pleural effusion may be divided into the immediate; or treatment of the effusion per se; and the subsequent management. In treating the effusion, the sheet anchor is rest and aspiration; the latter being performed preferably by siphonage or some apparatus similar to that of Potain. Some judgment must be employed, as to when aspiration is indicated and in brief the indications are:—a rapidly accumulating massive effusion, an effusion dis-

playing a tendency to chronicity and in those cases where symptoms and signs reveal respiratory and circulatory embarrassment. In some cases, with existing pulmonary tuberculosis, compression by a moderate size effusion is desired; the diseased lung thus being splinted. In fact it was the observation of beneficial effects, following a spontaneous hydro-pneumo-thorax, upon the tuberculous lung, that introduced the idea of therapeutic lung collapse. In addition to rest and aspiration, measures to promote absorption, are employed, such as restricted fluids, diuretics, purgation, hypertonic injections and heat. These measures as a rule are not particularly efficacious, since the pleural surfaces are inflamed and the bio-chemical and physical factors that function in absorption from the normal pleurae, are markedly hindered. Withdrawal of a small amount of pleural fluid and injecting it sub-cutaneously has been claimed by some as initiating absorption. In my experience this procedure has availed little. A very valuable procedure which has more or less lately come into vogue, is the withdrawal of fluid and its replacement by air. This procedure not only offers a better substitute for the compressed lung; not only facilitates the aspiration of larger amounts of fluid; but it is a valuable aid in preventing a complicating pulmonary edema. I have obtained some very satisfying results with this method in tuberculous empyema. Drugs play a minor role in treatment; but such drugs as iodine and the salicylates have enjoyed some favor in the past.

Now in regard to the subsequent care of the case:—and this is, as you may recall, my principle object in making this talk; I would like in conclusion to make one final plea. In every case of pleural effusion, in which no obvious explanation is forthcoming, consider it tuberculous and treat it exactly like a case of incipient pulmonary tuberculosis. It is in the incipient stage of this dreaded malady that we can most often obtain a cure.

**INDUSTRIAL HERNIA\***

**Kenneth McCullough, M. D.,  
Waycross, Ga.**

Hernia, as is shown from the earliest records of man, is one of the oldest recognized pathological conditions. Its treatment is described in records of the Sumerians as early as 4000 B. C., consisting of plasters, and bandages. As medicine passed through the successive phases of Egyptian, Greek, Roman, and Arabic civilizations, the treatment of hernia underwent various changes, until we come to Celsus in the first century A. D. who frequently operated for both umbilical, and inguinal hernia by either ligating, or excising the sac. Galen, a century later operated after the manner of Celsus, which in fact remained the classic method of treatment during the ancient, and mediaeval periods. Galen, through his dissections on animals, found that in monkeys, the tunica vaginalis is open, and believing that this was true in man also, was led to believe that a hernia occurred through a rupture in the peritoneum, and it was not until the dissections of Ruysch in the 17th century that the error of this belief was established. The term rupture, however, has been associated with hernia, both in the minds of the Medical Profession, and of the laity for so long a period that, even though we are aware of its incorrectness, the thought still persists, and it is this same term applied by Galen to a hernia which is responsible in a number of cases for its being considered as due to traumatism. During the early part of the Christian Era, and down through the middle ages, the treatment of hernia, as well as all other human ills, passed through various stages of development, though a great deal of it remained on a par with our modern quackery, and it was not until the 19th century that any great progress over the work of Celsus, and Galen was made. After this, discovery after discovery came in rapid succession, and we have the names of such famous men as Cooper, Scarpa, and still later Kocher, Bassini and others.

The subject of hernia is of course very

broad, embracing as it does, so many different types, and involving so many parts of the body. However, from the industrial standpoint, we are concerned mainly with the inguinal variety, and it is to this type which I shall confine this paper.

During the past few years, this subject has come to occupy a position of great importance, owing to the spread of special legislation in the form of Workmen's Compensation Acts which, in varying forms, have been passed by nearly every state. In this respect, many countries in Europe have been ahead of us, Germany having passed special legislation with respect to hernia as early as 1884. In former time, the question of trauma as one of the etiological factors of a hernia was usually left to the courts to decide, and their decisions, no matter how logically arrived at, were usually based on more or less unscientific reasoning. Now, however, these questions are coming more and more to be decided by experienced surgeons, and there are gradually being formulated certain standard rules by which to proceed in determining what effect, if any an alleged injury has in causing a hernia.

The true traumatic hernia is so extremely rare as to be practically negligible. It presuppose an injury of such severity as to puncture, or tear the abdominal wall in such a way that part of the viscera are extruded. Coley, in his work at the Hospital for Ruptured and Crippled, states that he has failed to observe one such case in a period of 31 years, and it is quite obvious that an injury of such severity must, almost of necessity result in death.

The so-called traumatic hernia, in which group are included all forms appearing during or after the act of lifting, falling, coughing, or straining, is the type with which we are concerned, and by a brief study of the abdominal wall, it can be pretty clearly demonstrated that there must be some congenital weakness existing prior to the act which is alleged to be the cause.

Lying external to the peritoneum, and separated from it by the preperitoneal fat, is the structure known as the intra-abdominal fascia. This fascia varies in strength, and is variously named according to its lo-

\*Read before the Augusta (1924) meeting of the Medical Association of Ga.



cation the diaphragmatic fascia, iliac fascia, etc., and at the point where it lines the transversalis muscle, it is called the transversalis fascia. Here it is very dense and strong, and it is with this fascia we have to deal in any discussion of an inguinal hernia. All structures leaving the abdominal cavity carry for a portion of their length a prolongation of the intra-abdominal fascia, and it is easily seen that at these points of exit, there is a defect in the abdominal wall. The internal inguinal ring, through which the spermatic vessels pass, therefore exists as a hiatus in the transversalis fascia which, at this point is prolonged upon them as the infundibuliform fascia. It is through this defect, or hiatus which an inguinal hernia develops.

Authorities differ as to the actual origin of a hernia. It is held by some that there is a congenital dimpling of the peritoneum at this weak point in those individuals who develop a hernia, and that the hernia is a gradual process, taking place over a varying period of time, as the intra-abdominal pressure undergoes changes from within, and without. Moschovitz, who is one of the greatest living authorities on hernia, denies the existence of a preformed sac or dimple, and believes that this dimple or indentation of the peritoneum is not congenital, but is due to an increase in the intra-abdominal pressure pushing the peritoneum into a weak, or abnormally large opening in the abdominal wall such as the internal ring. His principle being that the congenital origin of the hernia is not due to failure of the saccus vaginalis to be obliterated, but to a congenital weakness of the abdominal wall itself. This of course, must not be confounded with those cases of actual congenital hernia. It is the hernia which develops later in life with which we are concerned.

Now, if there is a congenital weakness, or enlargement of the internal ring, it is natural that the surrounding structures are also lax or weak, and that the external, or subcutaneous inguinal ring, instead of having its normal width of a scant half inch, is also enlarged, and patulous. This can easily be ascertained by palpation, and when

the external ring is found enlarged, it can be pretty safely assumed that the individual has, if not a potential hernia, at least a tendency towards one. Therefore, in considering an applicant for employment, this is an important feature of the examination. This question of enlarged rings has been given a great deal of discussion. It is only within the past few years that any definite data concerning them has been published. Watson, in his recent book on hernia, states that Colecord, in investigating open rings, wrote to a hundred surgeons for their opinion. Only 20 per cent of his replies were of the opinion that an open ring is a potential hernia. He found that in 9000 examination there were 784 individuals who had open rings (8.7 per cent), and 153 hernias (1.7 per cent) and of 24 patients who later developed hernias, only 3 had patulous rings at the time of examination (12.5 per cent). My own observations have shown that of 8000 men undergoing examination for employment at the A. C. L. Hospital Dispensary, 902, or 11.27 per cent had one or both rings patulous, while 112, or 1.4 per cent were rejected on account of hernia. Of 99 cases of hernia which were admitted to the A. C. L. Hospital, 79 had undergone examination at the time of employment, and 19, or 25 per cent had signed releases for patulous rings. This is exactly double the percentage shown by Colecord. These figures show the rather large number of men who are liable to develop a hernia at some time in life, and I believe that in spite of the opinion of a great many surgeons to the contrary, an open ring certainly indicates some congenital laxity of the abdominal wall. Our applicants were allowed to sign a suitable release covering the possibility of developing a hernia, and put to work.

Now, taking up the actual case of hernia as it usually presents itself, we find an individual appearing for treatment exhibiting a hernia on one or both sides. He gives a history usually of having lifted some heavy object, or of falling, or making a misstep, etc. Upon examination, he is found to have a well marked hernia which, to the practiced eye must obviously have been in existence for some time, and which could not have de-



veloped suddenly without at least producing symptoms of violent shock. Yet the patient will in all sincerity state that he noticed nothing wrong until he performed the act to which he attributes the origin of the hernia. The usual symptoms as he states them are that at the onset, he felt a sudden pain, or burning sensation in his groin, and upon examining himself, found the hernia. He is not nauseated, nor has he any of the symptoms which one would associate with a sudden pushing of the peritoneum through the internal ring. Another thing which you have probably all observed is the fact that when only one side is complained of, there is frequently found either a well marked hernia, or a widely patulous ring on the opposite side. I have seen this very frequently, and to my mind it shows very clearly that the individual, though probably ignorant of the fact, evidently had his hernia, or the tendency towards one for some time prior to the incident which first called it to his attention. In justice to the average patient I want to say right here, however, that he is perfectly honest, and sincere in making his claim, for only in a few isolated cases have I observed a hernia attributed to an accident which was afterward proven to have been in existence to the patient's own knowledge for some time prior to the alleged injury. Out of 93 cases coming under my care at the Atlantic Coast Line Hospital, 40 claimed an accident as the cause, while 53 did not. Of these 93 cases, 79 came to operation, and all were found to have a well marked sac, while six of them were direct; 14 refused operation, and of the 79 operated upon, there were four recurrences, or about 5 per cent. Two of these recurrences were in cases of direct hernia.

The operation done was usually the Bassini, or some modification of it to suit the individual case. In several, however, the cord was not transplanted. The steps of this operation being so well known, I shall not enter into details here other than to state that to effect a cure, the essential steps, high dissection of the sac, anchorage of the stump, and a secure buttressing of the conjoined tendon to the shelf of Poupart's ligament must be carefully carried out. For the im-

portant sutures, some prefer silk, others linen, and others catgut. I have obtained very good results with the latter.

In conclusion, if the statements I have made above are true, we must infer that the so-called traumatic hernia, or as it is very aptly termed by the French "hernia of effort," is a hernia, which, while probably not appearing until some sudden strain calls attention to it, has in reality been in existence either actually, or potentially for a long time. We must also be led to believe that a patulous external ring may be taken as an indication of a potential hernia. From this, it is very justly argued, that granting the existence of the hernia, or the tendency towards it, the accident, or strain has either called it to attention more prominently, or made it worse. This view is taken as reasonable by the Medical and Surgical section of the American Railway Association who, in addition to certain other recommendations regarding the examination of employees, etc., conclude their report with the following: "Any case of hernia developing in the course of duty, incident to the man's daily work should be treated as a disease due to special anatomic weakness on the part of the individual, the company is in no way responsible. If it is considered wise under certain circumstances to recognize any moral responsibility, let it be on an economic, or humane basis. This moral obligation should be strictly limited to employees who have been found apparently free from hernia at the time of a previous physical examination.

The Atlantic Coast Line Railroad has taken a very broad attitude in regard to these cases of hernia which develop after a man has entered its service. Our employees are treated both from a humane, and economic standpoint, and while we do not recognize an accident as the etiological factor in the origin of the average hernia, our policy is to render such treatment to the individual developing one as to cure him if possible, thereby rendering him better able to do his work. When you consider that the average efficiency of the man with a hernia is reduced 25 per cent, you can easily see that

this service not only renders aid to the man himself, but the employer profits by his increased efficiency.

#### BIBLIOGRAPHY

- Gray's Anatomy.  
Applied Anatomy—F. Treves.  
Johuson's "Operative Therapeutics"—Hernia by Alexis V. Moschowitz.  
Proceedings of Medical and Surgical Section—American Railway Association, 1923.  
Workmen's Compensation Legislation in U. S. and Canada—U. S. Department Labor Bulletin 332.  
Workmen's Compensation Acts in United States' Medical Aspects—Research Reference No. 61.

### SYMPOSIUM ON UROLOGY

#### ADVANCES IN RECOGNITION AND TREATMENT OF INFLAMMATORY BLADDER DISEASES\*

S. A. Kirkland, M. D.,  
Atlanta, Ga.

From time to time we encounter numerous changes in methods of determination and treatment of different diseases of the human mechanism. Some of these changes have been tested thoroughly and shown to be a marked improvement over some older diagnostic or treatment method; other changes are accepted for a length of time, "weighed in the balance and found wanting" then, relegated to the rear.

By using the word advances in my title it is not meant to convey that every diagnostic and treatment method referred to in this paper is an improvement. I merely mean to outline a few of the present day methods, even though some were in use years ago, and trust that these methods taken as a whole will show some atom of advancement along the lines of diagnosis and treatment of inflammatory bladder conditions.

I know of nothing, relating to the human anatomy that means more to a specialist from a diagnostic standpoint, than a thorough understanding of the bladder, does to the urologist.

For inflammatory conditions of the bladder, the urologist had made progress in his

diagnostic and treatment methods. Our increased knowledge and understanding of such diseases has been brought about by the modern methods of investigation, such as, improved laboratory technique and improved methods of instrumentation.

I know of no term that is more abused, than the one ordinarily applied to inflamed bladder conditions, viz, cystitis. Many physicians have hastily and erroneously concluded that they were dealing with a case of cystitis, just because they found an infected urine. The same rule relative to diagnosis, that applies to all other diseases should apply to these types of troubles; that is, a thorough examination before any diagnosis. Unless we make an accurate diagnosis our treatment can only be symptomatic and very often will result in dissatisfaction. In diagnosing; a good history means considerable: Information can be gained from a general inspection and one may be able to elicit by palpation, a supra-pubic tenderness or in some cases, feel a thickening in the supra-pubic region. In the majority of cases, one must rely on the cystoscope to enable him to arrive at the proper diagnosis.

Like numerous other diseases, there has been no clean cut classification of inflammatory bladder diseases. For convenience, some writers have grouped the different types according to the pathology, while others have found it simpler to name them in accordance with the etiology. It matters not with what type of bladder infection we are dealing, our present day methods invariably enable us to place our finger on the immediate trouble, thereby making it possible for us to render intelligent treatment without wasting our efforts trying every conceivable method prior to the proper one.

I wish to hesitate here long enough to state, that it is not my intention to try to convey that we have found infallible methods of diagnosis and specific treatments for bladder irritations. Since it has become possible through the aid of several noted urologists to successfully insert an electrically lighted instrument directly into the

\*Read before the Augusta (1924) meeting of the Medical Association of Ga.



bladder, enough improvements have been made on the original instrument to demonstrate that there is still a broad field for research work along these lines.

Since the advent of the cystoscope, the urologist has been able to make a more scientific diagnosis and of course, render more satisfactory treatment to the patient. We no longer refer to all cloudy urines as cystitis and we are able to eliminate a number of diagnoses which in the past we have conveniently labeled as idiopathic hematuria. It is not necessary as of old to await the development of the latter stages of a disease to assure the family and patient, if advisable, of some existing grave condition.

Another point which I think should not be passed without comment is the fact, that one is not only able to recognize inflamed bladder conditions readily, but we are oft-times able to diagnose the condition in its incipency; which of course will at times shorten and simplify the treatment of some cases, and of conditions that are not recognized until considered hopeless, it may be possible to resort to some measure which will add to the comfort and longevity of the patients life.

A goodly number of inflamed bladders are caused by foreign bodies or growths in the bladder. When we look through the telescope of our instrument and find these conditions, we are able to determine the location, size and in many instances the character, all of which are essential points in outlining the proper treatment. At times we encounter cases in which we have a profuse hemorrhage and it is very difficult to get a clear field, but with the use of the irrigating cystoscope, we can often obtain a momentary view. In some of these cases of hematuria it becomes necessary to put the patient to bed and with the use of the catheter allow the bladder to rest for a few days, before the bladder field is sufficiently clear, to enable one to make an intelligent diagnosis.

In treating bladder conditions, special attention should be paid to asepsis. Cleanliness and gentleness, I consider criteria for cure of these ills. Many inflamed bladders

are traceable to carelessness in handling cases of urethritis, stricture or inflammatory diseases of the prostate and seminal vesicals. This particular class of bladder case is very rare among physicians who use, aseptic precautions and discretion in the passage of instruments. Keyes made the statement that, "The cleaner you are the better, but the gentler you are the best." I think this statement is more applicable to bladder conditions than any disease of the nomenclature.

In acutely inflamed bladder conditions by keeping the patient quietly in bed and advising copious libations of pure water, good results have been obtained. The chief thing is water and more water in order to render the urine as bland as possible. Alcohol should be withheld although some German physicians advocate beer in cases where patients are accustomed to drinking it. It is always necessary, I think to keep these patients on a light nutritious non-irritating diet: Occasionally a strictly milk diet is warranted. It is very essential that the patients bowels should be kept freely open with mild laxatives, and an alkaline urine produced which can be done, by the administration of such drugs as bicarbonate of soda and potassium acetate.

For the relief of distressing urinary symptoms we invariably have to resort to anodynes such as sodium and potassium bromides. Often a suppository of  $\frac{1}{4}$  gr. Ext. Belladonna and  $\frac{1}{2}$  gr. Powdered Opium will relieve the tenesmus. When these measures fail to give relief, it becomes necessary to administer morphine and codeine hypodermically.

There are a number of urinary antiseptics with which one can combat the infection. If we are dealing with gonorrhoeal infection, I think some of the balsams should be used; in staphylococcic and streptococcic infection, I prefer hexamethylenamintetramine in connection usually with acid sodium phosphate. This drug can be pushed, except in cases of gastric disturbances, bladder irritability, or hematuria, should we get such ill effects it is an index for us to decrease or perhaps withhold the drug.



The simple remedies already mentioned when applied conservatively are very often all that is necessary to clear the infection, however, local measures should not be forgotten in treating acute conditions. In my opinion instillations should be accorded first place among the local remedies; the most effective being argyrol or mercurochrome.

I do not think irrigations have such an important place in the treatment of acutely inflamed bladders, however, if they are given mildly, with little pressure and no distension of the bladder, they are oftentimes very beneficial.

When we are dealing with a chronically inflamed bladder, the rules of diet and hygiene already outlined in acute conditions should be observed. Our first step should be to determine the cause, as these conditions are so often secondary to such diseases as pyelitis, pyelonephritis, pyonephrosis and tuberculosis. No doubt there are numbers of cases which have been treated for months and possibly years for supposedly chronic posterior urethritis when a discovery is made the case in question, is one of renal origin. For this reason, it is not wise to continue routine measures of treatment over a long period of time without a thorough investigation to determine the cause and directing our treatment to removal of same.

The principal internal therapeutic measures in treatment of a cystitis chronic are large amounts of water and hexamethylenaminetetramin. Irrigations are of paramount value such as; Nitrate of Silver Solution made with distilled water (1 to 5000), Bichloride of Mercury (1 to 60000), potassium permanganate (1 to 10000) and Boric Acid (2 to 3%).

Hagner, of Washington, has reported good results in alkaline cystitis with Bulgarian Bacilli. His method is very simple. He takes two or three tablets in a half ounce of water and adds a little milk sugar. After catheterization of the bladder, this emulsion is injected. Frequency of treatments depend on the severity of the disease. In some cases as much as two treatments a day are given.

Other urologist have reported cases in which good results were obtained with the *Bacillus Acidophilus*. My personal experience has been limited with either of these Bacilli.

As a chronically inflamed bladder is somewhat contracted, one essential in treatment is to enlarge its capacity. This can be done by clamping off the outflow of a two way catheter and distending the bladder daily by hydraulic pressure. Very often a bladder with a capacity of an ounce can be dilated up to about 500 c. c. within a short time, by this method.

The operating cystoscope is of paramount value in treating inflamed bladder conditions. One is able through the use of this instrument in connection with the high frequency machine to cauterize vegetations and ulcerations. Cases of hemorrhage in the bladder have been checked by applying the electrode directly to the bleeding points.

Young, of Baltimore, has devised several ingenious radium carrying instruments provided with cystoscopic barrels by which accurate application of radium can be made.

Quite a large number of bladder tumors are unsuitable for fulguration, endovesical radium treatment and extend over to large an area of the bladder for resection. Deep X-ray therapy can effectively be applied in a number of these cases.

In inflamed bladder conditions which are traceable to neoplasms, the inflammation invariably disappears entirely after the growth has been eradicated. I will not go into details of the methods of procedure for removing such growths; I do think, however, that the urologist should have diversified methods and be well skilled in all, in order to be able to apply the one that suits the particular case with which he is dealing.

### Conclusions

1. We should keep in mind the anatomical structure of the bladder in order that we might be more able to fully appreciate and combat the pathological conditions arising within the bladder.
2. Before making our diagnosis, it is essential that we give the patient a thorough

examination. As so many chronically inflamed bladders are of renal origin, it is not wise to continue routine measures of treatment over to long a period without investigating the case from a renal standpoint.

3. The cystoscope is of paramount value in diagnosing bladder conditions and practically indispensable in treatment of most inflamed bladder troubles.

4. Get an accurate diagnosis in every case if possible as this greatly facilitates treatment.

5. Have diversified methods of treatment and be well skilled in each method.

### THE NEGLECTED PROSTATE\*

Charles Hansell Watt, M D.,  
Thomasville, Ga.

It is not the purpose of this paper to propose a new method for treating the enlarged prostate nor to suggest a modification of the principles of treatment now in vogue; nor is it within the scope of this paper to discuss the advantages or disadvantages of the perineal or suprapubic operation. The sole object of this effort is to bring to your attention a few figures by means of which I hope to convince you that there are many elderly men in every vicinity suffering unnecessarily from prostatic obstruction. If this condition of affairs is appreciated then I believe there will be a better chance of correcting it and my remarks shall not have been in vain.

About three years ago a prominent surgeon of Southwest Georgia expressed the belief that there were many men in our vicinity suffering from prostatic obstruction who failed to receive the proper attention. This man does a great deal of surgery and his statement was based on his own records. As a result of this remark I decided to investigate the matter more thoroughly by means of a brief questionnaire which I sent to physicians in the immediate vicinity. I made this questionnaire short purposely in order that the busy physician could fill it out in a few moments and re-

turn to me in a self-addressed envelope; a long one would be more likely to find the waste-paper basket.

This questionnaire comprised only five questions as follows:

1. How many cases of prostatic obstruction, benign or malignant, came under your observation in 1921? Ans.

2. How many have you operated upon? Ans.

3. How many have you referred for operation? Ans.

4. How many are leading a partial catheter life, that is, need to be catheterized occasionally? Ans.

5. How many are leading a catheter life entirely? Ans.

This questionnaire was mailed to 236 physicians. Only 77 replies were received, that is, about 33 per cent, and 8 letters were returned because of death or insufficient address. Summary of these 77 replies shows:

1. Number suffering from	
prostatic obstruction .....	182,
2. Number operated upon by	
local surgeon .....	56,
3. Number referred for treat-	
ment (operation) .....	30,
Total operated upon .....	86, or 47%
Total unoperated .....	96, or 53%

Had replies been received from the 236 physicians, and in the same ratio, it undoubtedly would have shown at least 200 cases observed but still untreated in 1921.

Of these unoperated cases, 48, or 50 per cent, need to be catheterized occasionally because of complete retention of urine. Of the remaining 48, twelve (12) are leading a "catheter life" entirely. This still leaves 36 cases unaccounted for.

It is in the interest of the 53 per cent of untreated enlarged prostates that I come before you today hoping to provoke a discussion which will help us to fix the blame, if we may term it such, for the neglected prostate. Why did these cases not come to operation? I now regret that this question was not included in the list sent out but since it was not I hope we can find an answer for it here today. No doubt some of these have since come to operation; a few

\*Read before the Augusta (1924) meeting of the Medical Association of Ga.

may have been considered unfit for operation, but even with these concessions it seems to me the number of neglected prostates must still remain too great.

I have no means for fixing the responsibility in these cases but as there are always two sides to every question I believe one is safe in assuming that in some of these cases the patient himself is to blame while in others the advising physician must shoulder the responsibility.

I have in mind a case illustrative of each of these classes which I shall recite briefly. A prominent, well educated merchant of Southwest Georgia consulted a physician of my acquaintance complaining that he had frequent annoying dreams. After a careful history and general physical examination the patient was referred to me for an examination of the genito-urinary tract. He gave a definite history of difficulty in voiding with nocturia for the past few years. Rectal examination revealed a definitely enlarged prostate; voided urine showed many pus cells with a trace of albumen and a few casts. When preparations were made to test this patient's residual urine and bladder capacity he refused to have it done saying, "Doctor, I'd rather not have that done; I believe you are on the right track but I don't care to have you go any further with the examination." No argument I could offer would persuade him. I have not seen him since. This man had his convictions but was afraid to have them confirmed. My arguments were all in vain, therefore the responsibility is his.

Another patient with a definite history of prostatic obstruction consulted me stating that his family physician had been treating him for enlarged prostate but he did not seem to improve any. This treatment consisted in frequent prostatic massage and was given with the assurance that it would reduce the obstruction. On examination there was found a very large prostate almost filling the rectum. The voided urine, small in amount, contained a trace of albumen, many pus cells and a few granular casts. The introduction of a rubber catheter into the bladder withdrew 650 c.c. of residual urine. When the patient saw this amount of urine

withdrawn after he thought he had emptied his bladder he realized at once there was something radically wrong. When the condition was explained to him and operation advised he accepted the advice at once. Despite the fact that operation has afforded this patient complete relief his physician still maintains that it was unnecessary, that he could have relieved him by massage. With this belief existing this patient would never have been referred until in coma. This physician either possessed an exaggerated opinion of his ability as a masseur or else was sadly misinformed concerning the pathological condition with which he was dealing. In any event the fact remains that in this case the physician alone was responsible for the delay in coming to operation but it was not his fault that the kidneys were able to withstand the operation.

I do not wish to appear critical and for fear my remarks may be regarded as such I think it only fair to give the physician the benefit of the doubt and regard him as the representative of that class of honest, conscientious physicians who still believe that they are conserving the best interest of their patients by advising against prostatectomy. This belief on the part of some, honest though it be, is due to a failure to inform themselves of the results of this operation in the hands of skilled surgeons. Reducing the members of this class to a minimum therefore is a matter of education.

The few figures quoted above deal only with those cases in which the diagnosis of prostatic obstruction had been made. If the undiagnosed cases could be added I am certain these figures would be much larger. The man who is seeing and treating these cases frequently is not so likely to err as the one who in general work meets one occasionally. A better acquaintance with some of the suspicious symptoms will reduce to a minimum those sufferers who go without treatment until the kidneys have become permanently and hopelessly damaged. Again a case in point: An active man of 63 came to my office accompanied by his physician for the purpose of having a cystoscopic examination for a supposed cysti-



tis. He had been treated for a long time medically and had even taken a trip to a well known spring for the benefit the change of water might bring. This patient was unable to sleep at night because of marked nocturia, every 15 to 20 minutes. He was unable to make any social calls because of the urgent, frequent urination. There had never been complete retention of urine and apparently no reason for catheterization. I asked his physician if he had ever passed a catheter on him and the reply was that it had never been necessary as he seemed to pass the urine as rapidly as it collected in his bladder. Rectal examination revealed a huge benign hypertrophied prostate and when more than 600 c.c. of residual urine was withdrawn by catheter from the bladder the physician was manifestly surprised. He failed to grasp the fact that the residual urine was taxing this man's bladder capacity and the small amount being passed so often was the overflow.

By suspecting every man above fifty years of age who complains of bladder irritation such as nocturia, dribbling of urine, or difficulty in voiding, of having some trouble with his prostate many cases now evading early diagnosis will be classified. A finger in the rectum or a catheter in the bladder, passed after patient has voided, will often confirm the suspicion.

### CONCLUSION

1. Prostatic hypertrophy is not a sectional disease.

2. The few figures given above show that more than 50 per cent of those suffering from prostatic obstruction fail to receive proper treatment.

3. The figures given above cover a very small territory but what exists there undoubtedly exists elsewhere.

4. Prostatectomy, in skilled hands, is a safe and logical operation **provided** the patient comes to operation before the cardio-renal system has been greatly damaged.

5. To prevent severe damage to the cardio-renal system it behooves us to make the diagnosis of prostatic obstruction early and in justice to our patient present the facts to him and place the responsibility of accepting or rejecting the required treatment upon him.

### URETERAL CALCULUS BILATERAL, WITH TIME CHECK ON AT LEAST ONE STONE.\*

C. K. Wall, M. D.

Thomasville, Ga.

It has long been a question in my mind how rapidly stones are formed in the urinary tract. We have all seen cases of renal colic and noted the recurrent attacks, and even though most patients are relieved by the natural passage of their stones, quite a few are forced to the radiologist and the cystoscopist for more information as to the likelihood of obtaining non-surgical relief. It is only among this number that our information can be at all accurate as to the number and size of stones present, and then only with repeated observations can we tell anything of the rapidity with which stones are formed. It is not the purpose here to go into the chemistry of renal and ureteral calculi, but rather to record our observations on one case in particular and to correlate the some experiences of others along this same line.

Those of us practicing in limestone regions where patients drink largely of artesian water, notorious for its hardness, have occasion to see many cases of renal colic, so called, regardless of the location of the obstructing agent. These patients frequently pass small stones, one or several, as often as four times in a year. Most of this class of sufferers never come to the X-ray. They are relieved in most cases by the hypodermic use of morphia and atropin and immersion in a hot bath. However, they serve to indicate that in certain individuals at least, the formation of stones must be fairly rapid and more or less continuous.

Ochsner (1) relates an experience in this connection with a patient of his who had been a sufferer from renal colic, and after several years of relief from symptoms, the patient who was a boiler manufacturer, was asked if he had had any recent attacks. The patient replied that he was definitely through with renal colic, and suggested that if doctors used their intelligence in their profes-

\*Read before the Augusta (1924) meeting of the Medical Association of Ga.

sion as actively as boiler manufacturers had to in their business, no one would ever have to experience a second attack of renal colic unless he had more than one stone in his kidney to begin with. He stated that when his customers complained of their boilers filling up with lime in the form of scales, he advised them to use rain water, and that ended the trouble: so on the same principle he drank freely of distilled water and had been free from a recurrence of kidney stone and renal colic.

This matter of distilled water for this class of patients has long been a recognized procedure, but it is remarkable how many patients, victims of stone, and treated by many physicians have never been put upon distilled water as a possible means of warding it off. The writer has used this especially after operations for stones and although the time for most of them is still short, it has coincided with the theory of Ochsner's patient in all but one case.

This is the case of a young white man, H. S. B., 31, movie operator, referred to me by Dr. Cheshire of Thomasville, Aug. 21st., 1923. His personal history was devoid of interest except for smallpox as a child and loss of left eye in an accident at twenty-five. His first kidney attack was in June, 1922. This was in his left side and he says he thinks he passed a small stone at that time. Has been free from any further trouble till now. This attack came on an hour ago without any previous symptoms, no bloody urine, nothing. He is doubled up with violent pains in the left kidney region and radiating downward and into penis. Urine passed in the office is reddish and microscope shows many red cells. The urine is otherwise negative. X-ray shows a good-sized pear-shaped stone about one and a half centimeters by two centimeters, low down in the left ureter, apparently just outside of the bladder. Patient refuses cystoscopic examination. After three days of continuous pain which is only partially relieved by morphia and hyoscin, the attack let up and he was free for a week. At the end of that time he had another attack and while still refusing cystoscopic, he consented to opera-

tion. This was done Sept. 2nd, under ether through a low left rectus incision. The peritoneum was peeled back and the ureter exposed. It was the size of an index finger and very thick walled. The calculus was found about an inch outside the bladder in a pouch in the ureteral wall, very firmly embedded, and it required an incision fully as long as the stone itself through which to remove it. The ureteral incision was closed with fine catgut, interrupted, and a cigarette drain left at site of ureteral wound. Recovery was very smooth, no urine escaping along the drain and no pus after the first forty-eight hours. Patient left hospital twelve days after operation in good condition. Soon after his operation he was instructed to drink nothing but distilled water. He lived up to this with the exception of about a week during which he went on a huge spree and drank anything he could get. This was in December, 1923, some ten weeks after his operation and it was only a day or so after that his next attack of renal colic seized him. He said that he felt then a sense of fullness with dull pain in the upper right side. He also passed some bloody urine but thought little of it as the attack was not very severe. He did well then till Feb. 2nd, 1924. This was a hard cutting pain and he went down with it for three days. An X-ray now revealed a stone almost as large as the one found at first, but this one in the right pelvis, or as nearly as we could tell from the picture, and the patient still refuses any cystoscopic, hence no chance to localize by pyelogram.

A third radiograph taken, April 25th, shows the stone low down in the right ureter, although the patient has had no symptoms of any kind since the first attack on this side in February. It is hoped that he will pass this stone, or at least consent to cystoscopic manipulation in case of further trouble from it.

This patient in spite of distilled water has apparently formed a second stone since his operation in September, or five months previous to the finding of the stone by X-ray. This stone was probably the cause of his attack in December, ten weeks after operation



altho no X-ray observation was made at that time. Of course we have to bear in mind that this stone might have been there all the time; but we know that in two radiographs it shows very definitely, while in the first nothing is seen of it, hence it is our opinion that this stone has formed in the ten weeks following the first picture, and that it was the cause of his attack in December.

Dr. C. R. Robins of Richmond reports a case somewhat like this except that his X-ray observations led him to think that in his case two stones some two cm in diameter had formed in one month.

As to treatment in ureteral and renal calculus we can do no better than follow the principles of Schede, (3) who states that the object of treatment is in the first place, to remove a formed calculus; in the second place, to limit the injury thereby produced as far as possible; and in the third place, to protect the patient against a return of the trouble. The first two are being met amply by refinements in modern technique, but the third has apparently received very little attention.

In an article by Cabot and Crabtree (4), published in 1915, of a study of end-results in operations for kidney and ureteral stone performed in the Mass. Gen. Hospital for a period of eight years previous to 1914, we find the following figures somewhat astounding. In this they showed that 49 per cent of cases suffering from kidney stone and 29 per cent of cases suffering from ureteral stone recurred. This is really amazing to those of us who in the run of cases, make our diagnosis at operation and produce the stone, think we have done our duty. Our duty to the patient does not stop there; we owe it to him to do everything in our power to ward off any future attacks, for any condition that recurs after a surgical operation is a serious matter, and should not be left to chance if there is anything we can do to help it. Although we know as yet very little of the real cause of stone formation, we know that under certain conditions there is less likelihood of it and experience of others would seem to indicate that distilled

water is at present the one best bet; hence if we can do no more than explain to a patient the possibility of recurrence and warn him against it and put him on distilled water we may save him the second operation.

To quote from Robins again, "Notwithstanding all that has been said or can be said, the conclusions of Cabot and Crabtree, in my opinion, are thoroughly sound. I trust that further experience will enable us to improve our results, but at the present time this is as far as we can go. They say 'On the basis of these cases we can only say to the patient that the risk of operation is small; that the danger of progressive destruction of the kidney by the stone, if it is left, is considerable; that it depends somewhat upon the age of the patient, undoubtedly somewhat upon the method of operation and the skill with which it is carried out, but clearly upon an entirely unknown factor—the liability of that particular kidney to form concretions.'"

#### BIBLIOGRAPHY

1. Ochsner, A. J. Stone in the Kidney and Ureter, Jour. A. M. A. Oct. 11th, 1919. Vol. 73, pp. 1103-1108.
2. Robins, Chas. R. Recurrence of Stone in the Kidney, Surg. Gynec., & Obst., Chicago, 1918 XXVI, 270, 277.
3. Prof. Schede. Von Bergmann's System of Practical Surgery, 1914, Vol. V., Chap. XIV.
4. Cabot and Crabtree, Frequency of Recurrence of Stone in the kidney after operation. Surg. Gynec. & Obst. 1915 XXI 223.

#### DISCUSSION ON SYMPOSIUM ON UROLOGY (Papers of Drs. Kirkland, Watt and Wall)

DR. JAS. L. ESTES, Atlanta: Regarding Dr. Kirkland's paper on cystitis, after we have concluded as to the causative factor the patient usually comes with complaint of pain, frequently of urination and bleeding. Sometimes this is very distressing. After we have made our investigations we are not at all times able to conclude at one examination what had best be done.

One thing about the treatment of these bladder conditions. First, you want to know the kind of bacteria, for the treatment varies with the organism present.

Dr. Kirkland mentioned that irrigation is of less importance than instillations. One can instill a patient's bladder with quite a quantity of urine in it and not get results after the bladder is empty. The thing we think should be done is to thoroughly empty the patient's bladder with a glass catheter and with the Guyon or some other instillator introduce the medicine directly. If this is not done we do not get re-



sults. Sometimes a patient is sent in by a doctor for instillations and the treatment is given with the bladder half full of urine, but it is very necessary that it go directly to the mucosa. When there is no response to silver solution it is quite wise to make an investigation. At times a 10 per cent. silver nitrate solution immediately washed out with water will cause desquamation of tissue and injure the treatment.

These instillations should be made daily. We should insist upon daily treatment, or twice a day if necessary.

I think for internal medicine by mouth water is our best agent.

In regard to patients with hypertrophy, the patients do not know what to do when we mention operation. We have to get up on the blind side and sort of tease them along. When a patient comes with frequency of urination if we tell them at once that we must operate 75 per cent of these patients will not return.

DR. HARRY Y. RIGHTON, Savannah: I wish to congratulate the gentlemen on their very valuable papers. Dr. Wall brought out the question of cystitis. I think this is better named "cystopathy," which is not original with me. Cystitis is always accepted as a secondary, never as a primary condition. The condition he brought out I think should be stressed, and that is that in the cases of pyuria the cause should be established by the cystoscope. The case may be very painful at first but it is only a question of time and palliative agents until one can use instruments and make a diagnosis. Therefore, treatment I consider is only secondary to diagnosis.

Regarding Dr. Watt's paper on prostatic obstruction, I agree that early diagnosis is very important and that we should not wait until we can feel a very much hypertrophied prostate for evidence of obstruction. Sometimes we find a median lobe that acts like a ball valve and causes obstruction. A patient under sixty years, had 600 c. c. residual urine due to a prostate, which was not palpable through the rectum but had a median lobe involvement which was only diagnosed by means of the cystoscope.

Regarding Dr. Wall's paper on ureteral stone, he particularly brought out the point regarding rain water. I do not agree with him thoroughly for I think it has been tried out and proved not of much virtue. It is a question whether it will decrease the amount of urinary salts. I think for prophylaxis we should look in another direction. If there is low grade pyelitis that has helped to form the stone, this should be removed by getting better drainage, clearing up the ureter and the pyelitis.

In regard to X-ray examinations, they are not at all dependable in ureteral stone. I think in the cases where he said it was not in evidence at first, it was either a uric acid or phosphatic calculus, which afterward became evident due to calcium deposit. I have pictures taken of patients complaining of renal calculi and no stone showed in X-ray, but by means of a wax tipped catheter the stone was demonstrated and passage was induced.

DR. JULIAN K. QUATTLEBAUM, Savannah: I wish to cite one case in reference to the use of distilled water. A young girl was complaining of hematuria and low grade toxemia. X-ray examination showed five stones in the left kidney, but in spite of this the kidney was functioning with surprising efficiency, probably 90 per cent. of normal. I did not feel like advising removal when it was doing so much service, and having read the work of Ochener regarding distilled water, I advised her to drink copiously of it. Six weeks later we had another picture taken by the same man and found the stones much smaller, and

two months later several of the stones had disappeared and the fever had subsided. This continued for a year, at which time she removed from Savannah to a small town and being unable to get distilled water she quit the treatment. Later on she returned to Savannah and we found the shadows had become markedly larger in her absence, although she had only four at that time. She began drinking distilled water again and the shadows have become much smaller. This is interesting in the light of the circumstances.

DR. RUFUS C. FRANKLIN, Swainsboro: In discussing Dr. Wall's paper, in the matter of prophylaxis and treatment I wish to call attention to the recent experiments at the Mayo Clinic. Regarding infection, particularly from the teeth, tonsils and urine. They have carried out experiments over a considerable period of time. These experiments consisted in part in devitalizing teeth in dogs under sterile dental conditions and the pulp cavities of these teeth infected with cultures—of bacteria from teeth, tonsils or urine of patients with results that stones were produced in the kidneys of dogs. The results of these experiments are new and very important work in connection with focal infection, as a causative factor, and I think we should take this into account in the management of all our cases of nephrolithiasis.

DR. ROY J. HOLMES, Wadley: I believe that papers such as we have listened to this morning will be instrumental in finally convincing the rank and file of the medical profession that urology is something more than the treatment of venereal diseases, and that improved diagnostic methods have made this one of the most exact and scientific of all specialties. There is no condition I know of where the patient can be promised as much relief from symptoms after timely operative interference or as much suffering and discomfort through neglect, as in true hypertrophy of the prostate. We must remember that this condition is inevitably progressive. The patient may have relief for a short time but the hyperplasia progressively increases, and, in this respect, true hypertrophy differs from most diseases associated with old age, most of which tend to atrophy. There is no interval over which we may hope to tide our patients and look for improvement. The treatment is purely surgical and if we can get these patients to consent to operation before grave infections of the upper urinary tract occur we can promise relief in fully 80 per cent. of our cases. We know that the average life of the prostatic patient after initial obstructive symptoms begin, is only five years. Catheter life reduces this expectation of life almost 50 per cent. or to two years and ten months, to be exact.

I wish to say a word regarding distention of the so-called retracted bladder. Contrary to what has been written. I believe that the ureteral orifices are frequently relaxed in these diseased bladders and that it is possible to force fluids up the ureters and even into the kidney pelvis. Therefore, we should be very careful in any attempt to distend the bladder mechanically. After removing stones from the ureter or kidney, I do not regard my treatment as completed until systematic irrigations of the kidney pelvis with silver nitrate solutions have corrected any abnormality in the urine from that kidney. While we have removed the stone we have not removed the cause for its development, and this, quite often I believe, is an old pyelitis which furnishes the material for the formation of a nucleus. Calculi do not develop in normal urines, and it is our job to restore the urine to normal and correct any existing pathological condition after the calculus has been removed.

DR. C. K. WALL, Thomasville (closing on his part): I did not mean to give the impression that in giving rain water to these patients they had to go out and

catch it off the roof. I was addressing my paper principally not to the men who are doing cystoscopic work, they know how, but to the man out in the country, ten or twenty miles from the hospital. Those are the fellows who see a lot of these patients with renal calculi and have to stick them in a hot bath, and those are the ones we want to help out. The men in town can dilate the ureter and wash out the pelvis, and if there is any question about it can refer the patient to those who are more competent than themselves, but our efforts should be directed to the less fortunate doctors who are so situated that they cannot have all this assistance.

I am glad that Dr. Franklin brought out the work at the Mayo Clinic. I think that was very well put but I did not bring this out because I was talking mostly to the men out in the state.

DR. C. H. WATT, Thomasville (closing): I wish to thank the gentlemen for discussing the papers and to say a word about Dr. Kirkland's paper. He spoke about the use of large amounts of water in treating cystitis, particularly chronic cystitis. I did not understand whether he said it was useful in acute cystitis. Personally, I have had better results in limiting the water and making these patients take as little as possible. The first principle in treating any inflamed surface is to put it at rest. If we are giving the patients water all the time they must use the bladder to get rid of it, but if we put them on a little soda or something to alkalinize the urine and limit the fluid intake in the acute stages we will get better results.

## THE ANNUAL CONFERENCE OF STATE SECRETARIES

The annual conference of the secretaries of constituent state medical associations was held at American Medical Association headquarters in Chicago, November 21-22. Dr. E. A. Hines, South Carolina, was chosen to serve as chairman, and Dr. T. B. Throckmorton, Iowa, as vice-chairman. Thirty-seven secretaries were in attendance, together with twelve editors of state medical journals, the members of the Board of Trustees, the President, President-Elect and the Treasurer of the Association, and the executive heads of its councils and bureaus. The proceedings were marked by spirited and frank discussions. Criticisms were not withheld, but were offered and received in the spirit that should, and does characterize earnest men who are conscientiously striving to advance a worthy cause. The papers presented and the discussions are to appear in the Bulletin, beginning with this number and it is hoped that our readers will find interest in this material, which presents the ideas and convictions of those who are charged with administering the affairs

of medical organization and medical journalism in their respective states.

The conference this year endorsed and committed its members to the prosecution of a definite plan for increasing the membership and extending the influence of county, state and national societies by bringing into affiliation reputable and qualified physicians who have heretofore withheld from membership. It is not the purpose of the state secretaries to "put on a drive," but rather to appeal in a dignified way to those who are in all respects eligible. Necessary preparations for carrying out the plans approved are now under way.

The tendency of state associations toward the employment of whole-time secretaries was made very apparent at this year's conference by the presence of four officers who have been selected to serve in such capacity within the last two months. Three of these are laymen.

The outstanding impression that one gets from these gatherings is that the men who attend them are earnestly anxious to render real service to the organizations they represent and to advance the cause of scientific medicine. It is evident that they want to know what they think they should know and that they seek information from all available sources. It is equally evident that they are quite ready to share the knowledge they have gained in their administrative experiences with all their fellows. Our state secretaries and editors are striving worthily to do their jobs and they deserve wholehearted encouragement and support. —A. M. A. Bulletin.

## PALPATION HEMATURIA AS A TEST IN FLOATING KIDNEY

After the patient has voided, Morris H. Kahn, New York (Journal A. M. A., Nov. 29, 1924), palpates one or both kidneys, exerting only mild pressure during three inspirations of the patient. After a few minutes, the patient voids again for a comparable microscopic examination. In many cases of nephroptosis in which the kidney could be held down by the palpation hand for several inspirations, bleeding was produced by palpation trauma. In a few cases, when the lower part of the kidney was palpable, this was not possible. The kidneys are apparently sufficiently sensitive to direct pressure or palpation trauma that care should be taken not to induce microscopic hematuria. The urine should be examined before the physical examination is made, before the kidneys are palpated. A mistaken diagnosis of hematuria may result from neglect of this suggestion.



# THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Profession of Georgia.

65 Forrest Ave., Atlanta, Ga.

FEBRUARY, 1925

ALLEN H. BUNCE, M. D., Editor  
 M. C. PRUITT, M. D., Business Manager  
 Publication Committee  
 CHAS. USHER, M. D.  
 S. J. LEWIS, M. D.  
 T. C. THOMPSON, M. D.

Articles are accepted for publication on condition that they are contributed solely to this Journal.

Manuscripts should be typewritten, double-spaced, and the original (not the carbon copy) submitted. Used manuscript is not returned unless requested.

Communications and items of general interest to the profession are invited from all parts of the State. We especially invite county society secretaries to send us information of happenings in the county that would be of interest to the members throughout the State.

## Editorial Department

### SOUTHERN PEDIATRICS

In the south, within the last six years, there has been no branch of medicine that has made more rapid and commendable strides than has Pediatrics. This fact argues well for southern medicine. When it is realized that 75 per cent of properly directed activities of preventive medicine lie in pediatrics, also that one-fourth to one-third of the general practitioner's practice is directed to the pediatric span of life—birth to 15 years of age—then the true value of this development may be properly realized.

Prior to 1918 there existed no definite organization of pediatrics in the south,—although badly needed. At the Atlanta meeting of the Southern Medical Association, 1918, five southern pediatricists secured permission, from the Council, to organize a pediatric section, as a component part of the Southern Medical Association. Permission was reluctantly granted, with many doubts and misgivings accompanying it. It was said there were not enough pediatricists in the south, or enough interest in this branch of medicine, to warrant the creation

of a section. Today it has been said to be the "livest wire" in the Southern Medical Association. The recent yearly attendance on Pediatric Section meetings has been from 200 to 300 southern pediatricians.

At Asheville meeting, 1919, the Pediatric Section inaugurated a wise movement, by which the southern general practitioners would be helped with their pediatric problems. The activating idea of the move being, that general practitioners treat more babies than do pediatricists, therefore to elevate pediatric practice in the south, the general practitioners, as well as the pediatricists, must be reached. Accordingly State Pediatric Societies were organized, through the activities of members of the Section, in all southern cities. The purpose of the State Pediatric Societies was clearly defined—primarily to reach general practitioners, secondarily to interest pediatricists. Pediatric Section meetings, held at State Medical Association meetings, in which pediatricists banded themselves together to read technical papers for the benefit of one another, were forbidden. The main purpose was to present broad-gauged, timely pediatric papers before the general meeting, and thereby in a general way disseminate necessary pediatric knowledge. In this way the general practitioners were to be kept informed on the essential points and recent advancements in pediatrics.

As a matter of information it might be said that Georgia was the first State to organize a State Pediatric Society—1918, one year before the Asheville meeting.

In 1921 the Southern Pediatric Seminar was organized. The Seminar has proved itself to be a very strong and important cog in the wheel of organization of southern pediatrics. It is today the largest attended post-graduate course, in pediatrics, given in America. It consists of a two weeks' intensive didactic and clinical course, given at Saluda, N. C., during the month of August. It is altruistic from start to finish, the welfare and physical betterment of southern babies and children is its only goal. The faculty and special lecturers are all southern physicians—pediatricists, or physicians



specializing in branches closely allied to pediatrics. No member of faculty or special lecturer receives one cent of financial emolument, but on the contrary loss of time from practice, railroad fare and all other expenses are defrayed by each individual member. In addition the Constitution and By-laws safeguard any possibility of division of accumulated funds, by stating that such funds, if accumulated, shall be utilized for the interest and welfare of southern babies and children.

The morale at the Seminar is unique and inspiring. The student body has caught the altruistic spirit, and as a result class organizations have been formed throughout the various southern States. The members of these class organizations are as much enthused over the Seminar as is the teaching staff. The result of such a happy combination of circumstances is that the Seminar is yearly growing in a most commendable manner.

Letters from national associations interested in infant and child welfare work have been received, commending the Seminar and its work, and at the same time expressing their regrets that similar Seminars do not exist in the North, East and West.

Southern Pediatrics has been developed along a preconceived and well thought out plan. Pediatrics as practiced in the south today is on as high a plane, as that practiced in any other section of the country. Let's make it a little better. If you get an opportunity to boost southern pediatrics do so, thereby helping every baby and child in our southland.

MULHERIN.

### THE DIAGNOSIS OF PULMONARY TUBERCULOSIS

In a recent article, Brown and Heise (*Amer. Rev. of Tb.*, July, 1924) discuss the five diagnostic criteria of the Trudeau Sanatorium and give the results in follow-up studies of 264 cases observed from one to seven years. The criteria are: (1) The history of an hemoptysis of a teaspoonful or more; (2) the occurrence of pleurisy with effusion; (3) the presence of persistent moderately coarse rales in the upper half of the

chest; (4) a definite parenchymatous X-ray lesion of a tuberculous character in the upper half of the chest; and, (5) tubercle bacilli in the sputum.

Tuberculosis did not subsequently develop in any of the 203 cases in which all these signs were absent. Only 2 of 61 doubtful cases developed demonstrable clinical tuberculosis. Furthermore, any patient who fails to react to 10 mg. of "O. T." rarely develops active tuberculosis. When the five criteria are absent, we can safely state that the patient has not got active pulmonary tuberculosis.

### MEDICAL EXTENSION IN ONTARIO

Several years ago the Committee on Education of the Ontario (Canada) Medical Association took active steps to carry post-graduate instruction to its members. They secured the co-operation of the Medical Faculty of the University of Toronto and that of Queen's and Western. A schedule of lectures was prepared and developed which has grown until now over 300 topics are included. The subjects covered last year were: Internal Medicine; Pediatrics; Surgery; Obstetrics and Gynecology; Therapeutics and Pharmacology; Hygiene and Preventive Medicine; Oto-Laryngology; Pathology; Physiology and Biochemistry; and, Radiology. The schedule has been worked out in co-operation with local societies. Local talent has been used where possible to assist in the teaching.

Three plans have been used: (1) Individual lectures to form the chief part of the regular programs of the society meetings. (2) Individual lectures apart from society meetings. Under this plan the members of a local society formed a group for post-graduate instruction. (3) Lectures and demonstrations given in series. Three or more lectures or demonstrations were arranged to form a symposium on a subject selected by the local society. The choice of subject and selection of speakers was left entirely to the local group.

More than 100 teachers have assisted by giving lectures and demonstrations. These gave over 300 lectures last year. Generous help from the Red Cross has enabled the

Association to offer to send as many as eight speakers to any affiliated society and pay all traveling expenses, including an honorarium to each speaker. The Ontario Medical Association is helping to develop a higher type of individual practitioner and thereby rendering a service not only to its members but to the community as a whole.

### **TEXAS ASSOCIATION INCREASES DUES**

The State Medical Association of Texas has increased its annual dues from \$5.00 to \$15.00, beginning January 1, 1925. In commenting upon this 300 per cent increase in dues, Dr. Holman Taylor, Secretary, states in the December issue of the Texas Journal, "We learn from several secretaries of state associations where dues have recently been raised materially, that in only a few instances have there been any losses in membership, and then in every case these losses have been more than compensated for in a short time. It seems that the increased efficiency of the organizations has appealed to the membership, and that the pride in the organization when it begins really to accomplish something, compensates manifold for the additional cost."

### **MICHIGAN STATE SOCIETY INCREASES DUES**

The Michigan State Medical Society has recently increased its annual dues to \$10.00 for the purpose of employing a full time executive secretary at a salary of \$4,800.00 per year and traveling expenses. The new executive secretary, Mr. Harvey George Smith, will discharge his duties over the direction of the Secretary-Editor, Dr. F. C. Warnshuis, and the Executive Committee of the Council. The Michigan State Society had 2800 members in good standing at the end of last year.

### **CHOOSING YOUR DOCTOR**

In a recent article in the Saturday Evening Post on the subject of "Choosing Your Doctor," Dr. Woods Hutchinson gives some valuable information for both the physician and the public. Of especial interest to the

doctors are the following paragraphs in reference to post-graduate study and attendance at medical meetings:

"A most significant detail to be inquired into is whether your prospective doctor has the post-graduate habit, if he is still a student, keeping up with progress of medicine, taking frequent trips to the great medical centers for post-graduate and polyclinic courses of study, and as often as he can afford it, to the great European hospitals and schools.

"Scarce less important, is he a regular attendant at the meetings of his local, state and, as often as possible, of the national medical societies? If not, he is slowly but surely ossifying and falling behind the procession, for nothing can take the place of constant contact, discussion, and comparing of notes with his colleagues. The doctor who has stopped studying and discussing has stopped thinking. The intelligent general public demands higher standards from its doctors than ever before; and it has a right to.

### **THE AIM OF THE UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE**

We have recently received a new Bulletin from the University of Pittsburgh School of Medicine. The University of Pittsburgh was chartered as "Pittsburgh Academy" in 1787, to provide higher education in western Pennsylvania. Throughout its long history, it has been supported by the public-spirited citizens of Pittsburgh and by the State. The aim of this School of Medicine may be profitably studied by every one interested in medical education.

"The aim of the School is properly to prepare the student for the practice of scientific medicine; to teach him medical ethics and the history of medicine so that he may do his full duty to the people and understand his obligations to his fellow-practitioners; to teach him his personal responsibility in the support of proper standards and ideals in medicine; to educate him so that he may intelligently evaluate the latest developments and utilize only those which are found to be true and sound in principle."

## District and County Societies

The Secretary of each county society shall report to the Journal of the Medical Association of Georgia full minutes of each meeting and forward to it all scientific

papers and discussions which the society shall consider worthy of publication.—Constitution and By-Laws, Chap. VII, Sec. 15.

1. Demmond, E. Carson, Savannah.
2. Wood, A. W., Albany.
3. Greer, Chas. A., Oglethorpe.
4. Blackmar, Francis B., Columbus.
5. Clay, Grady E., Atlanta.
6. Hawkins, T. I., Griffin.

7. McCord, M. M., Rome.
8. Carter, D. M., Madison.
9. Bennett, J. C., Jefferson.
10. Lee, F. Lansing, Augusta.
11. Penland, J. E., Waycross.
12. Cheek, O. H., Dublin.

### HONOR ROLL

The following is a list of 100 per cent counties for 1925. The date on which each became a 100 per cent society appears after the name of the society, together with the name of the Secretary:

1. Randolph County, Dr. G. Y. Moore, Cuthbert, December 9, 1924.
2. Dougherty County, Dr. J. A. Redfearn, Albany, December 10, 1924.
3. Pike County, Dr. M. M. Head, Zebulon, December 12, 1924.
4. Hart County, Dr. W. E. McCurry, Hartwell, January 3, 1925.
5. Warren County, Dr. A. W. Davis, Warrenton, January 14, 1925.

### SIXTH DISTRICT MEDICAL SOCIETY

The Sixth District Medical Society held a meeting December 3, 1924, at the Hotel Dempsey, Macon. The following papers were read:

"Anencephalic Monster. Report of a Case," Dr. O. R. Thompson, Macon.

"The Treatment of Fibroids and Goiter by Deep X-ray Therapy," Dr. F. A. Sprague, Macon.

"Infections," Dr. A. F. White, Flovilla.

"Reconstruction of Penis Following Injury," Dr. C. C. Harrold, Macon.

"The Treatment of Diabetes and Use of Insulin," Dr. T. E. Rogers, Macon.

"The Irritable Bladder," Dr. Wallace L. Bazemore, Macon.

"General Life and Death on Battle of the Common Cold," Dr. Maury M. Staples, Macon.

The election of officers resulted in:

President—Dr. T. E. Rogers, Macon.

Vice-President—Dr. Kenneth Hunt, Griffin.

Secretary-Treasurer—Dr. T. I. Hawkins, Griffin.

### MUSCOGEE COUNTY MEDICAL SOCIETY

The December meeting of the Muscogee County Medical Society was held at the City Hospital, Columbus, December 4, 1924. The meeting was called to order by the President, Dr. J. H. McDuffie, Sr. Dr. W. L. Cooke, Columbus, described a case of ureteral calculus operated upon. Dr. J. C. Woolbridge spoke of six cases of Brill's disease he had seen. In the discussion, Dr. J. H. McDuffie, Sr., stated that he had only seen two clear cut cases and Dr. J. A. Thrash, Columbus, remarked that Brill's disease was often thought to be Typhus but that he did not think we were justified in diagnosing Typhus on clinical evidence alone. The date for the meeting of the Fourth District Medical Society was set for Thursday, June 18, 1925. As there was no further business the meeting adjourned.

FRANCIS B. BLACKMAR, M. D.,  
Secretary.

### WILKES COUNTY MEDICAL SOCIETY

The Wilkes County Medical Society held its monthly meeting Tuesday, January 6, 1925, at Washington. This is a "live-wire" society and plans for making this their best and most active year were made. In addressing the meeting, Dr. A. W. Simpson, President of the Eighth District Medical Society, stated that a campaign all over the District was to begin soon and that he, Dr. H. M. Fullilove, Athens District Councillor, and Dr. D. M. Carter, Madison, District Secretary, would make trips into every County within their District in order to stimulate interest among the members. One of the important subjects discussed was the Washington General Hospital to which every



member pledged his support. The following are members of the Wilkes County Medical Society: Dr. Lewis R. Casteel, Metaspville; Dr. Thos. C. Clodfelter, Tignall; Dr. L. M. Ellis, Washington; Dr. R. J. McNeil, Danburg; Dr. E. W. Ragsdale, Tignall; Dr. H. M. Sales, Rayle; Dr. G. W. Sherrer, Rayle; Dr. A. W. Simpson, Washington; Dr. R. A. Simpson, Washington; Dr. C. E. Wills and Dr. O. S. Wood, Washington.

#### **BUTTS COUNTY MEDICAL SOCIETY**

The members of the Butts County Medical Society were delightfully entertained by one of its best loved members, Dr. A. F. White, at a bird supper at his home in Flovilla. Dr. White was assisted by Mrs. White and their daughter, Miss Virginia White. He has represented his County Society as Delegate at several of the past annual meetings of the Association and is on the State Board of Medical Examiners. The guests present were: Dr. J. W. Harper, Jenkinsburg; Dr. W. H. Steele, Jackson; Dr. O. B. Howell, Jackson; Dr. Eugene B. Elder, Superintendent of the Georgia Baptist Hospital, Atlanta; Dr. Herbert White, Atlanta; Dr. B. F. Akin, Jenkinsburg; Dr. H. W. Copeland, Jackson.

#### **COUNTY SOCIETIES REPORTING FOR 1925**

##### **Fulton County Medical Society**

The Fulton County Medical Society announces the following officers and committees for 1925:

President—Dr. Theodore Toepel, Atlanta.

Vice-President—Dr. J. L. Campbell, Atlanta.

Secretary-Treasurer—Dr. Grady E. Clay, Atlanta.

Dr. B. H. Wagnon was named a member of the Board of Censors.

Committee on Public Policy and Legislation—Drs. C. E. Waites, C. C. Aven and John W. Turner.

Committee on Public Health—Drs. Frank Wells, John F. Denton and Hal M. Davison.

Committee on Publicity—Drs. W. R. Holmes, Jack W. Jones and Paul W. Best.

Committee on Arrangements for annual meeting in Atlanta of the State Association, May 13, 14 and 15th: Drs. E. C. Thrash,

Chairman; W. L. Funkhouser; Grady E. Clay; O. D. Hall; R. G. Stephens and Allen H. Bunce and Theo Toepel, ex-officio.

Board of Managers—Dr. E. D. Shanks, Atlanta.

##### **Hart County Medical Society—100 Per Cent**

The Hart County Medical Society was the first County to report a 100 per cent membership during January. It announces the following officers for 1925:

President—Dr. T. R. Gaines, Hartwell.

Vice-President—Dr. A. O. Meredith, Hartwell.

Secretary-Treasurer—Dr. W. E. McCurry, Hartwell.

Delegates—Drs. B. C. Teasley and W. E. McCurry.

Board of Censors—Drs. W. E. McCurry, T. R. Gaines and J. C. Jenkins.

##### **Worth County Medical Society**

The Worth County Medical Society announces the following officers for 1925:

President—Dr. J. L. Tracy, Sylvester.

Vice-President—Dr. H. S. McCoy, Doerun.

Secretary-Treasurer—Dr. W. C. Tipton, Sylvester.

Delegate—Dr. W. C. Tipton. Alternate—Dr. H. S. McCoy.

Board of Censors—Drs. W. W. Sessions, G. S. Sumner and J. J. Crumley.

##### **Hall County Medical Society**

The Hall County Medical Society announces the following offices for 1925:

President—Dr. R. L. Rogers, Gainesville.

Vice-President—Dr. L. G. Neal, Cleveland.

Secretary-Treasurer—Dr. Pratt Cheek, Gainesville.

Delegate—Dr. J. K. Burns; Alternate—Dr. J. B. Rudolph.

Board of Censors—Drs. C. D. Wheelchel, J. B. Rudolph and J. B. Mauldin.

##### **Bartow County Medical Society**

The Bartow County Medical Society announces the following officers for 1925:

President—Dr. T. Lowry, Cartersville.

Vice-President—Dr. H. B. Bradford, Pine Log.

Secretary-Treasurer—Dr. W. E. Wofford, Cartersville.

Delegate—Dr. W. E. Wofford; Alternate—Dr. H. B. Bradford.

Board of Censors—Drs. W. C. Griffin, R. E. Adair and S. M. Howell.

#### **Carroll County Medical Society**

The Carroll County Medical Society announces the following officers for 1925:

President—Dr. O. R. Styles, Bowdon.

Vice-President—Dr. J. B. Camp, Carrollton.

Secretary-Treasurer—Dr. C. C. Fitts, Carrollton.

Delegate—Dr. Claude Griffin; Alternate—Dr. D. S. Reese.

Board of Censors—Dr. D. S. Reese, Carrollton.

Necrology—Dr. O. W. Roberts, Carrollton.

#### **Sumter County Medical Society**

The Sumter County Medical Society announces the following officers for 1925:

President—Dr. Kenneth Wood, Leslie.

Vice-President—Dr. Henry Simpson, Smithville.

Secretary-Treasurer—Dr. E. B. Anderson, Americus.

Delegate—H. A. Smith; Alternate—Henry Simpson.

#### **Crisp County Medical Society**

The Crisp County Medical Society announces the following officers for 1925:

President—Dr. T. E. Bradley, Cordele.

Vice-President—Dr. A. J. Wheelchel, Cordele.

Secretary-Treasurer—Dr. J. H. Baxter, Cordele.

#### **Turner County Medical Society**

The Turner County Medical Society announces the following officers for 1925:

President—Dr. H. M. Belflower, Sycamore.

Vice-President—Dr. F. W. Rogers, Ashburn.

Secretary-Treasurer—Dr. J. H. Baxter, Ashburn.

#### **Grady County Medical Society**

The Grady County Medical Society an-

nounces the following officers for 1925:

President—Dr. J. B. Warnell, Cairo.

Secretary-Treasurer—Dr. J. V. Rogers, Cairo.

Delegate—Dr. J. V. Rogers; Alternate—Dr. A. B. Reynolds.

#### **Warren County Medical Society— 100 Per Cent**

Warren County is the fifth Society reporting 100 per cent membership for 1925. It announces the following officers for this year:

President—Dr. H. L. Earl, Jewell.

Vice-President—Dr. F. L. Ware, Warrenton.

Secretary-Treasurer—Dr. A. W. Davis, Warrenton.

Delegate—Dr. F. B. Ricketson; Alternate—Dr. G. R. Maner.

Board of Censors—Drs. H. L. Earl and A. W. Davis.

#### **Irwin County Medical Society**

The Irwin County Medical Society announces the following officers for 1925:

President—Dr. G. W. Willis, Ocilla.

Vice-President—Dr. A. Harper, Wray.

Secretary-Treasurer—Dr. L. L. Whiddon, Ocilla.

#### **Colquitt County Medical Society**

The Colquitt County Medical Society announces the following officers for 1925:

President—Dr. J. A. Summerlin, Hartsfield.

Vice-President—Dr. S. M. Withers, Moultrie.

Secretary-Treasurer—Dr. M. H. Stuart, Moultrie.

Delegate—Dr. J. A. Summerlin; Alternate—Dr. J. F. Covinton.

#### **Cook County Medical Society**

The Cook County Medical Society announces the following officers for 1925:

President—Dr. H. W. Clements, Adel.

Vice-President—Dr. W. M. Shepard, Adel.

Secretary-Treasurer—Dr. L. R. Hutchinson, Adel.

Delegate—Dr. S. G. Ethridge; Alternate—Dr. W. M. Shepard.

**Chatham County Medical Society**

The Chatham County Medical Society announces the following officers for 1925:

President—Dr. J. K. Train, Savannah.

Vice-President—Dr. W. R. Daney, Savannah.

Secretary-Treasurer—Dr. A. A. Morrison, Savannah.

Delegates—Drs. J. R. Bean and H. T. Exley.

Board of Censors—Drs. R. V. Martin, H. Y. Righton and H. W. Hesse.

**Henry County Medical Society**

The Henry County Medical Society announces the following officers for 1925:

President—Dr. R. L. Crawford, Locust Grove.

Vice-President—Dr. J. B. Weldon, Hampton.

Secretary-Treasurer—Dr. W. P. Sloan, McDonough.

Delegate—Dr. R. L. Tye, McDonough.

**Tri County Medical Society**

The Tri County Medical Society announces the following officers for 1925:

President—Dr. C. J. Jenkins, Edison.

Vice-President—Dr. S. P. Holland, Blake-ly.

Secretary-Treasurer—Dr. C. K. Sharp, Arlington.

Delegate—Dr. C. J. Jenkins; Alternate—Dr. J. G. Standifer.

Board of Censors—Drs. C. R. Barksdale, P. E. Griffin and P. H. Fitzgerald.

**Telfair County Medical Society**

The Telfair County Medical Society announces the following officers for 1925:

President—Dr. Frank Mann, Lumber City.

Vice-President—Dr. W. H. Powell, Lumber City.

Secretary-Treasurer—Dr. C. J. Maloy, Helena.

Delegate—Dr. J. K. Maloy; Alternate—Dr. W. H. Powell.

Board of Censors—Drs. W. H. Born, B. M. Kennon and W. B. Yawn.

**BOOK REVIEW**

**GENITO-URINARY DISEASES AND SYPHILIS**, by Henry H. Morton, Professor of Genito-Urinary Diseases and Syphilis in the Long Island College Hospital. Fifth edition, revised and enlarged, containing 698 pages with 328 illustrations and 38 full colored plates. Published by the Physicians and Surgeons Book Company, New York City.

The author, who has had many years of experience in this line of work, has collected much valuable material in the new and revised edition of his book. The illustrations, numbering 328, and the colored plates are very good and instructive. The volume begins with a chapter on the aspect of turbid urine, following which are chapters on haematuria, kidney function tests, radiography, cystoscopy, urethroscopy, a description of the various diseases of the penis, gonorrhea and its complications, the various diseases of the kidneys, ureters and bladder, diseases of the prostate and seminal vesicles, surgical operations of the genito-urinary tract and many other interesting chapters devoted to this branch of medicine. The last chapter, which is devoted to various aspects and treatment of syphilis, although concise, gives much valuable information. His description of the various phases of gonorrhea and its complications is thoroughly carried out. Special attention is given certain chapters on impotence and sterility, granuloma inguinale, treatment of syphilis in children, etc. Because of the difficulty of putting every phase of genito-urinary disease and syphilis

S. J. SINKOE, M. D.

**A CORRECTION**

In the Directory list, December issue, Dr. H. J. Williams' name was given as Secretary-Treasurer of the Crisp County Medical Society. This was an error, however, as Dr. B. Daniel, of Cordele, was in that office during 1924 and has been re-elected for 1925. Dr. Williams was Secretary-Treasurer during 1923.



## Medical Progress

With the cooperation of our associates we propose to publish under "Medical Progress" abstracts from current medical literature of general interest to the

profession. Members of the association are invited to contribute to this Department.

Anderson, W. W., Pediatrics  
Ballenger, E. G., Urology  
Bartholomew, R. A., Obstetrics  
Block, E. B., Neurology and Psychiatry  
Clay, Grady E., Ophthalmology  
Downman, C. E., Neuro-Surgery  
Eguen, M. S., Otology, Laryngology and Rhinology  
Fitts, Jno. B., Internal Medicine  
Greene, E. H., Surgery

Hodgson, F. G., Orthopedics  
Holmes, Walter R., Gynecology and Female Urology  
Jones, Jack W., Dermatology  
Klugh, Geo. F., Clinical Pathology  
Landham, J. W., X-Ray and Radium  
Pruitt, M. C., Proctology  
Thrash, E. C., Internal Medicine  
Waits, C. E., Surgery

### OLD DISABILITIES OF THE HIP

There are a number of old chronic disabilities of the hip joint which were formerly classed as incurable. Such conditions as old ununited fractures of the neck of the femur, old dislocations of the hip, either congenital or pathological, old osteo-arthritic conditions causing pain and disability. In recent years a number of operative procedures have been devised which give great relief to these chronic sufferers.

In old ununited fractures of the neck of the femur where the neck has been absorbed and there is no chance to get a union, there are two operations which can be used. The reconstruction operation of Whitman consists in cutting down upon the great trochanter, removing it with its muscular attachments, from the femur, exposing the hip joint, removal of the head of the femur from the acetabulum and inserting the upper end of the femur into the acetabulum, the leg being in moderate abduction. The trochanter is then re-attached to the shaft of the femur lower down than normal. Wound is closed and a plaster spica applied holding the leg in abduction. This is worn four or five weeks, then removed and motions begun in the hip joint. About the sixth week a caliper brace is applied and the patient allowed up on crutches. This gives a good weight bearing limb with some motion in the hip joint. The other operation for this condition devised by Dr. Brackett of Boston is similar, but causes less shock as the head of the femur is not removed from the acetabulum. The trochanter is exposed and removed as above, the head is then exposed and the fractured surface of the head freshened and gouged out. The upper end of the femur is freshened and shaped so as to

fit into the head. The leg is abducted and the approximated raw bony surfaces are thus held in apposition. Wound closed and a plaster spica applied in abduction. This is kept on eight to ten weeks to allow bony union. Then the patient is allowed up with caliper brace and crutches. This gives a very useful limb and good hip motion.

Several operations have been devised to stabilize old dislocated hips which are causing pain and disability. The head of the femur and side of ilium are exposed by the Smith-Peterson incision. Instead of trying to replace the head of the femur in the acetabulum a new socket is formed on the side of the ilium above the acetabulum, and the head of the femur placed in this and held in position by moderate abduction and a plaster spica. This gives a stable hip with limited motion and it is much more useful and free from pain.

In old hips which are very painful due to chronic arthritic conditions we may relieve the pain by one of two methods. First we may destroy the joint surfaces and cause a complete ankylosis. This gives a painless hip, but it is also motionless. Another method is to resect the neck of the femur and produce a false joint. This gets rid of the pain, but gives an unstable joint. By wearing a caliper brace for six months, until a false joint is formed, these patients can get along very well with the use of a cane only.

So the chronic sufferers from various old hip conditions can often be given relief by some of the modern surgical procedures. None should be condemned to a life of suffering and disability until the advisability of one of these surgical procedures has been carefully considered.

FRED G. HODGSON, M. D.

## PROGRESS IN THE TREATMENT OF DEAFNESS

One of the sad pages in medical progress has been the realization of the fact that very little advancement has been made in the treatment of deafness. Any new method or line of procedure which offers some hope in the betterment of these individuals should be most gladly received. The old line of treatment even if a most exact diagnosis has been made as to its pathology and location, has certainly been very unsatisfactory.

During the last few years the treatment of deafness by means of minute doses of X-ray has opened up a new field of therapeutic measures for the deaf and while the claims for this line of treatment have not been unduly optimistic, certain results have been obtained which we believe will establish it as one of the positive aids in the management of these unfortunate cases.

Much credit is due Dr. Charles F. Stokes of New York in his attempt to work out the X-ray treatment on a scientific basis. We mean by this the proper selection of cases, the mode of application and the strength of the rays to be used. Dr. Stokes has shown that these cases are only benefited by the very weakest rays which act as a stimulant and not as a destructive agent. Large machines and heavy voltage are not adapted for this method of treatment. Dr. Stokes' theory of its action upon the hearing apparatus is most ingenuous even if he cannot prove the same by objective evidence. Briefly stated the mild rays electronize the cells through which they pass, stabilize those of weaker chemical and electrical affinity, stimulate the pituitary body which is the main governor of body metabolism and thus bring about a change both chemically and electrically. This line of treatment would be especially valuable in that form of deafness known as oto-sclerosis where there has been found to be a spongification of the labyrinth capsule and other adjacent osteoplastic tissues. Such has been found to be the case and the results obtained by Stokes and McCoy of New York, Richardson of Washington, Roy of Atlanta, Ivey of Vienna, Austria, lend much support to these hy-

potheses. What these changes are, cannot of course be determined unless we could know the histology of these cells in vivo and the pathologic changes after death, and as this seems to be impossible the only stable fact to be accepted is the testing of the hearing before and after treatment which in this way would give us a positive knowledge as to its benefits.

Frey of Vienna is very enthusiastic and has been publishing for some time the results obtained by him in this method of treatment. These results have been very decidedly optimistic.

If this treatment can obtain results which have not been obtained by any other methods of treatment and certainly the reports indicate that such is a fact, it certainly offers a boon for the afflicted deaf and in conjunction with other well known therapeutic procedures, it furnishes the otologist something tangible in his management of this large class of deaf people.

MURDOCK EQUEN, M. D.

---

## NEWS ITEMS

Dr. W. Frank Wells, of Hapeville, has been appointed Vice-Chairman of the Fulton County Board of Health. Dr. Wells is a member of the Fulton County Medical Society and was sent as a Delegate to the 1924 meeting of the Association in Augusta.

---

Dr. Charles Hamilton, formerly of Alapaha, and a member of the Berrien-Lanier Counties Medical Society, is now located in Ray City.

---

We have just learned that Dr. S. F. McIntosh, one of our former members, is now Assistant Medical Director of the Volunteer State Life Insurance Company, Chattanooga, Tenn. While Dr. McIntosh was located in Georgia he practiced in Chickamauga and was a member of the Walker County Medical Society.

---

Dr. E. R. Anthony, Jr., of Griffin, and past Vice-President of the Spalding County Medical Society, is now in the U. S. Public Health Service and stationed at Fort Stanton, New Mexico. Dr. E. R. Anthony, Sr.,

an honorary member of the Spalding County Medical Society, is the father of Dr. Anthony.

---

Dr. Henry Thomas Burns announces the opening of offices at 106 East 60th Street, New York. Dr. Burns was graduated from the Emory University School of Medicine in the Class of 1920. Practice limited to Gynecology and Obstetrics.

---

Dr. W. E. Edwards, formerly of Cordele, and a member of the Crisp County Medical Society, has been made head of the Espiritu Santo Springs Sanitarium at Safety Harbor, Florida. He has just recently returned from New York and Hot Springs where he was in training for his new position.

---

Dr. Frank Eskridge, Atlanta, was elected President of the Medical Staff of the White Unit of Grady Hospital, at the annual meeting, January 6, 1925. Dr. Montague Boyd Atlanta, was named Vice-President and Dr. W. H. Hailey, Atlanta, Secretary-Treasurer. Drs. Eskridge, Boyd and Hailey are members of the Fulton County Medical Society.

---

Dr. Maxwell Harbin, of Rome, has left for Cleveland, Ohio, to accept the appointment as Professor of Orthopedic Surgery at Western Reserve University and Orthopedic Surgeon to Lakeside and Rainbow Hospitals. He is a graduate of University of Georgia, College of Medicine at Harvard University and has had internships at Peter Bent Brigham and Children's Orthopedic Hospitals at Boston. Dr. Harbin is a nephew of Drs. R. M. and W. P. Harbin, owners of the Harbin Hospital at Rome.

---

Dr. Hugh M. Lokey, Atlanta, attended the annual convention of the Chi Zeta Chi Medical Fraternity, at Augusta, January 1, 1925. Dr. Lokey holds the office of Supreme Advisor.

---

Dr. Marvin F. Haygood, formerly a member of the Fulton County Medical Society, associated with the State Board of Health, is now located in Knoxville, Tenn., as Health Officer.

Dr. Frank P. Norman is being welcomed in Columbus, having opened offices in the Murrah Building. Dr. Norman was formerly the acting Secretary of the Meriwether County Medical Society, and was located at Greenville. He will limit his work to Pediatrics.

---

Dr. Howard E. Felton has been unanimously re-elected Commissioner of Health for Bartow County for a term of four years by the County Board of Health, of which Dr. Sam Howell is a member. Both Drs. Felton and Howell are residents of Cartersville and members of the Bartow County Medical Society. Dr. Felton represented his Society as Delegate at the last annual meeting in Augusta.

---

Dr. S. B. Liggin has removed from Montezuma and is now practicing in Columbus. Dr. Liggin was formerly a member of the Macon-Taylor Medical Society.

---

The General Assembly, at its recent session, endorsed the bill appropriating \$5,000.00 to the Georgia State Board of Health to aid in Maternity and Infant Hygiene. The federal appropriation of the same amount will make \$10,000.00 to help our State in this work.

---

Dr. C. L. Ridley, Macon and Bibb County Health Officer, has made a series of addresses on Toxin-Antitoxin at the various schools in his territory. Every child at the Methodist Orphanage, Macon, 150 in number, has been given the treatment for prevention of diphtheria.

---

The new colored ward of the Dublin Clinic, at Dublin, has been completed, together with other improvements. Moving this to the ground floor has given much more room on the second floor.

---

Clarke County has taken over the Athens General Hospital, at Athens. The County was enabled to purchase this with money obtained from the recent sale of \$200,000 worth of bonds. The citizens also voted \$50,000 worth of bonds for construction and maintenance of a tuberculosis hospital.



Sumter County public health workers administered a total of 5,024 doses of anti-typhoid vaccine, comprising 1780 complete vaccinations, during 1924. Dr. J. W. Chambliss, of Americus, a member of the Sumter County Medical Society, is a member of the Health Board of his County.

The friends of Dr. A. F. Weathers will be interested to learn of his return to Georgia after practicing for some time in Florida. Dr. Weathers has located in Hahira. He was formerly of Shellman and a member of the Randolph County Medical Society.

The John D. Archbold Memorial Hospital, which is being built in Thomasville, is nearing completion. It is expected to be ready for opening about March 1st.

The City Council (Atlanta), which is composed of 36 members, represents 17 distinct professions. The doctors are in the lead with six representatives, or one-sixth of the law-making body. The physicians who will help mould the laws for Atlanta during 1925 are: Drs. W. B. DuVall, P. L. Moon, C. C. Aven, C. J. Vaughn, W. M. Ethridge and Luther P. Baker, all members of the Fulton County Medical Society.

The Coastal Plain Hospital at Tifton, which was recently destroyed by fire, has been re-opened in the Jesup Home on south Park Avenue and began receiving patients the first of the year.

The 1924 record of the Department of Health of Savannah has shattered all previous records. Only two Savannah people died with typhoid fever the whole of last year, and the death rate from malarial fever has been reduced to 3.3 per 100,000 population; 13.4 being the lowest previous figure.

The late Major C. Downing, Brunswick, bequeathed \$5,000 to the City Hospital of Brunswick. The money is being held in trust until the Board of Commissioners decide on a suitable memorial to Major Downing.

The citizens of Vidalia are very proud of the Vidalia Hospital, which is operated by Dr. T. C. Thompson. During 1924 it was enlarged so that now it is equipped with an X-ray machine, sterilizers, laboratory and surgery of the most approved kind. Dr. T. C. Thompson is Surgeon and Dr. J. E. Mercer Internist, both being members of the Toombs County Medical Society. Dr. Thompson is Councillor from the Twelfth District and Dr. Mercer is a past President of his County Society.

Brunswick has taken a forward step to safeguard its citizens. An ordinance has been passed, which is to come into effect April 1, 1925, that all meats for human consumption offered for sale within the city limits must be slaughtered and dressed in an abattoir which has been approved by the State Veterinarian. The city commission of Brunswick is to be congratulated upon the passage of this ordinance.

The First Annual Meeting of the American Heart Association was held at the New York Academy of Medicine, February 2, 1925.

The main tour of the Inter-State Post Graduate Clinic Tour of American Physicians will be from May 18th to July 6th, 1925, with tours to Canada, British Isles and France. For further information write to Dr. William B. Peck, Managing Director, Freeport, Illinois.

## COMMUNICATIONS

Atlanta, Ga., Jan. 21, 1925.

Dear Doctor:

Lee Whitaker has been soliciting membership for the American Medical Association. We wired the A. M. A. for his authority; below is a copy of the telegram received in reply:

Chicago, Ill., Jan. 16, 1925.

Grady E. Clay, Sec. & Treas.

Fulton County Medical Society,  
Atlanta, Ga.

Lee Whitaker is not authorized to solicit membership for us.

(Signed) AMERICAN MEDICAL ASSO.

**THE AMERICAN HEART ASSOCIATION**

The American Heart Association, with offices at 370 Seventh Ave., N. Y., has recently been organized for the study and prevention of heart disease. The following letter was received from Dr. Stewart R. Roberts, representative of the Membership Committee in Georgia:

Dear Doctor Bunce:

You have recently received a letter from Dr. Haven Emerson with a reprint enclosure telling you of the problem of Heart Disease and the organized effort now under way to combat this, our greatest public health problem.

The moral and financial support of the public is necessary to our success. We need the moral support of your active membership and your interest in our work.

As the local membership representative of the American Heart Association in this section, may I urge you to become a member, and in so doing forward this very worthy cause?

Sincerely yours,

STEWART R. ROBERTS,

Representative, Membership Committee,

20 Ponce de Leon Ave., Atlanta, Ga.

Those desiring further information should communicate with Dr. Roberts or with the headquarters of the Association.

To The Editor:

On February 1st, 1925, I will open Brook Haven Manor for the reception of a limited number of patients who are in need of rest and upbuilding under medical supervision and should you have any patients of this type I would be more than glad to have you place them there. This institution has been established to fill a demand for patients who are in need of more individual care, privacy and homelike surroundings than is available in other institutions of a public or private nature. It is located on Peachtree Road, Atlanta, at Brook Haven Post Office and is about fifteen minutes by motor from the city. The estate comprises five acres of beautiful lawns, cultivated gardens and magnificent oaks. A prize Jersey cow and a plentiful supply of highly bred chickens

insure an abundance of fresh milk and eggs. A competent head nurse will see that all of your orders are promptly executed.

It is my desire that you will feel that this is your institution and that your interests will be safeguarded at all times. Moreover, I sincerely trust that you will not hesitate in making whatever constructive criticism that you feel will improve the management.

Very sincerely yours,

N. M. OWENSBY, M. D.

Atlanta, Ga.

Atlanta, Ga., December 4, 1924.

To The Editor, Colorado Medicine:

In your issue of November 29, 1924, page 1794, Colorado Medicine, Denver, a case of fatal poisoning from calomel is reported by Burnett and Pestal. The history of the case with symptoms are so impossible from taking four grains of calomel in two doses that I must come to the defense of a much used and useful drug and possibly a much abused drug. I will ask that you again publish the review and then my criticism in order that we might have a free and full discussion.

If you follow the report slowly you will find there was nothing wrong until the salts (I presume Epsom salts) were given next morning. Why not blame the salts which could have had arsenic as an impurity or some other drug could have been taken by mistake. Swelling of the gums is often found in ulcerative stomatitis from various causes. The blood in the stools might have been from uterine-hemorrhage and not from the epistaxis. It is impossible to cause epistaxis or uterine-hemorrhage from any form of mercury, even the bichloride.

Four grains of calomel in two doses is a very good diuretic. In large doses of bichloride poisoning you get suppression with acute parenchymatous degeneration, even deposits of lime are found in the uriniferous tubules, especially the convoluted ones. These chalky deposits, while not pathological of mercurial poisoning, are very suggestive of it. No doubt this woman had taken calomel before and had no idiosyncrasy.

It seems to me there was a lack of thorough examination during life and certainly a post-mortem was the proper thing after death. It is the report of just such cases that the manufacturer of patent laxatives "feed on" and advertise in circulars and in the daily press. The report of this case has just about nauseated me but so far I am free from epistaxis or uterine-hemorrhage.

S. A. VISANSKA, Ph. G., M. D.

**Fatal Poisoning from Calomel.**—Burnett and Pestal record the case of a woman who having been somewhat constipated, took eight one-half grain tablets of calomel in two doses. She slept well that night and on arising took one heaping tablespoonful of salts. Immediately thereafter she became nauseated and took about a half cupful of coffee, which did not stop the nausea, and in about a half hour she had a copious bowel movement and then began vomiting. The next morning blood appeared in the stools and vomitus persisted. Swelling of the gums and suppression of urine appeared, lasting four days. Epistaxis appeared; also uterine hemorrhage which lasted two days. She was given two doses of hemoplastin which effectively checked her hemorrhages, but following the second dose she developed a severe urticarial rash. Her vomiting, however, did not cease. She was given potassium acetate solution per rectum by the drop method, which she retained fairly well, and her kidneys became active so that she passed about 30 ounces of urine in twenty-four hours. In spite of this she declined and died nineteen days after taking the calomel.

—Colorado Medicine—Nov., 1924.

Lamar, Colo., Jan. 1, 1925.

Samuel A. Visanska, Ph. G., M. D.,

Atlanta, Ga.,

My dear Doctor:

I note your letter in the January number of Colorado Medicine and desire to say that it is not my intention to further nauseate you as it might bring on



that uterine hemorrhage that you claim you haven't had as yet and I fear for the consequences should you get one, but will only remark that had you perceived that report with ordinary care you would have found therein that the patient did have a serious time following the taking of calomel, when in her eighteenth year.

It is just such letters as yours that are usually signed by a galaxy of titles.

Very truly yours,  
JOSEPH PESTAL.

Dr. Joseph Pestal  
Lamar, Colo.

Dear Doctor:

Your rather "curt" note to hand and don't know just what your "stuff" is at the bottom. I had a right to criticize the review in the A. M. A. Journal and only requested a free and full discussion, not something in a note which I am unable to translate. Come out like a man and discuss matters in the Journal. An evangelist once said, "It's the hit dog that yelps."

Fraternally,  
S. A. VISANSKA.

### ANNOUNCEMENT

The Ninth Annual Clinical Session of the American Congress on Internal Medicine will be held in Washington, D. C., March 9-14, 1925.

Washington clinicians and investigators of attainment will devote the entire session to amphi-theatre and group clinics, ward "rounds," laboratory conferences, lectures, demonstrations of special apparatus and methods, and the exhibition of unusual scientific collections. Civilian and governmental services are united in the aim to make the week useful and memorable.

Practitioners and laboratory workers interested in the progress of scientific, clinical and research medicine are invited to take advantage of the opportunities afforded by this session.

Address enquiries to the Secretary-General.

Wm. GERRY MORGAN, Pres.,  
Washington, D. C.

FRANK SMITHIES, Sec'y.-Gen'l.

1002 N. Dearborn Street,  
Chicago, Ill.

### OBITUARY

Dr. H. H. McGee, Sr., Savannah, died Wednesday morning, January 7, 1925, at the Savannah Hospital, of which he was chief of the staff. He had been ill since the middle of October and came to Atlanta during December to undergo treatment but it did not prove of any benefit.

In the death of Dr. McGee, the Association has lost one of its ablest workers. He was a past President of the Chatham County Medical Society and represented it as Dele-

gate at the 1924 annual meeting in Augusta. At the time of his death he was President of the First District Medical Society.

Dr. McGee is survived by his widow, two daughters and two sons, one of them being Dr. H. H. McGee, Jr., recently named house physician at the Savannah Hospital under his father. The doctors acting as honorary pallbearers were: Drs. J. O. Baker, R. V. Martin, Charles Usher, D. B. Edwards and Thos. S. Clay. Among the active pallbearers were: Drs. A. A. Morrison, G. T. Olmstead, Henry Levington and R. L. Jackson.

Dr. William Parker, of Irwinton, died at the Rawlings Sanitarium, Sandersville, January 6, 1925, from septicaemia. He was graduated from the Atlanta Medical College in 1904 and served for years as County physician of Wilkinson County. Dr. Parker was fifty-one years of age.

Dr. A. L. Wilkins, of Eastman, died January 1, 1925, at the age of forty-five. Dr. Wilkins telephoned his wife from his office in the presence of two patients and asked that she send for him as he was not feeling well, then turned from the instrument and fell dead on the floor. It is supposed that an attack of heart failure caused his death. Dr. Wilkins had been a prominent physician of Dodge County for twenty years, having moved to Eastman from Jesup in 1904. He was Vice-President of the Ocmulgee County Medical Society and a director in the Eastman Kiwanis Club. He is survived by his wife and three brothers.

Dr. William J. Jennings died suddenly at his home in Thomasville, January 6, 1925, from angina pectoris, at the age of fifty-one. He was born in Terrell County and after graduating in medicine in Baltimore, he practiced in Blakeley, moving to Thomasville about twelve years ago. Dr. Jennings had to retire from practice about three years ago on account of ill health and moved to his country place just beyond Thomasville. Dr. Jennings was member of the Thomas County Medical Society.



**ABSTRACT OF THE MINUTES OF THE  
MEETING OF THE BOARD OF TRUS-  
TEES OF THE A. M. A., HELD AT  
HEADQUARTERS, CHICAGO,  
NOV. 20-22, 1924**

The date for the fall meeting of the Board of Trustees of the A. M. A. was fixed with the idea of affording the Trustees opportunity of spending at least some time in attendance at the conference of state secretaries and editors on November 21 and 22.

The Board met at 10:15 a. m., Thursday, November 20. The meeting was called to order by the Chairman, Dr. Walter T. Williamson. There were present: Drs. McDavitt, Browning, Dowling, Heekel, Upham, Richardson, Mitchell and Walsh; also the ex-officio members, Drs. Pusey, Haggard and Warnshuis; the Treasurer, Dr. Austin A. Hayden; and the Secretary, Dr. Olin West.

The minutes of the September meeting of the Board and of the October meeting of the Executive Committee of the Board were read and adopted with slight modifications.

The Acting General Manager presented a report, which was received with the understanding that the matters covered therein would be considered seriatim.

**Publications of the Association**

The subscription price of the Archives of Otolaryngology, to be issued January 1, was fixed at \$6 a year.

Because of the increased costs of publication and in order that still further improvement may be made in these journals, the subscription price of the Archives of Dermatology and Syphilology, of the Archives of Neurology and Psychiatry and of the Archives of Surgery was increased from \$6 to \$8 a year.

On account of the development and the extension of the scope of the Quarterly Cumulative Index, the annual subscription of this publication was raised to \$8.

**Financial Affairs of the Association**

There was extended discussion of the financial affairs of the Association in connection with the extension of its service, the growth of its departments, the increased size of its plant, and its program for the future.

Detailed financial statements were presented and considered by the Board.

The Acting Editor and the Acting Business Manager appeared before the Board and submitted statements concerning their respective departments.

**Honorarium for Editorial Boards of Special Journals**

It was voted to provide an increased honorarium for the editorial boards of the special journals of the Association, beginning Jan. 1, 1925.

**Gorgas Memorial**

After extended discussion of the plans of the Gorgas Memorial outlined in a statement for publication by Dr. Franklin H. Martin, director general of the Gorgas Memorial, and careful consideration of the statements submitted by Dr. Martin to the House of Delegates at the San Francisco and Chicago sessions, of the report of the Reference Committee to which Dr. Martin's statements were referred, and of the resolutions adopted by the House of Delegates on recommendation of that committee, the Board of Trustees directed that the plans of the Gorgas Memorial Institute, as outlined in the letter submitted by Dr. Martin, be discussed in the editorial columns of The Journal. It was the sense of the Board that the House Delegates had intended to approve, and had approved, the Gorgas Memorial Institute for research in, and for the teaching of, tropical medicine; and that any endorsement of additional plans of the Gorgas Memorial should come from the House of Delegates.

**Hygeia**

The policy of Hygeia, its cost to the Association, and plans for its development and enlarged circulation were thoroughly considered by the Board. The report of the Acting General Manager showed the present circulation of Hygeia to be larger than at any previous time.

**Department Budgets**

It was decided that, as far as feasible, all bureaus and councils of the Association shall be required to submit budgets for the consideration of the Board at its annual meeting to be held in February.

(To be continued in March issue.)



## A NEW SQUIBB PRODUCT

TO supply a need of the medical profession, the Squibb Laboratories announce the perfection of a distinctive and superior agar-oil emulsion. It will be marketed under the professional title

### *Squibb's Liquid Petrolatum with Agar*

This new Squibb preparation is made with Squibb's Liquid Petrolatum (Heavy, Californian), known for over twelve years as a pure naphthene oil of exceptionally high natural viscosity.

➔ Squibb's Liquid Petrolatum with Agar has a dry agar-agar content three times as great as that of similar preparations on the market.

It is absolutely free from oily taste, and its creamy consistency, pleasant taste and proven therapeutic efficacy, assure its universal favor with patients as well as physicians.



**E. R. SQUIBB & SONS, NEW YORK**  
MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.

# **THE JOURNAL**

## **OF THE**

# **MEDICAL ASSOCIATION OF GEORGIA**

DEVOTED TO THE WELFARE OF THE MEDICAL PROFESSION OF GEORGIA

PUBLISHED MONTHLY under direction of the Council

Volume XIV

Atlanta, Ga., March, 1925

No. 3

## **Original Articles**

### **THE TREATMENT OF BONE AND JOINT TUBERCULOSIS\***

**Lawson Thornton, M. D.,  
Atlanta.**

Normal, healthy bones and joints are kept at the height of physiological perfection by weight bearing and motion, but when infected with tubercle bacilli absolute rest is required to check the progress of the disease. The toxins produced by these organisms are almost entirely destructive in their action on animal tissues. Defensive and constructive elements of pyogenic inflammations are almost entirely absent. The tissues which the tubercle bacilli select are of poor blood supply and of low resistance—for example, joint cartilage and lymphoid cells adjacent to the epiphyseal line. Unfortunately, too, the osseous and cartilagenous tissues infected are most often where there is the greatest motion and weight-bearing function to perform.

The natural process of healing consists in walling off or encysting the diseased areas by deposits of lime salts. Crushing or fracturing these walls of defense permits further spread of the destructive infection. For this reason absolute immobilization is necessary to arrest the disease. If the areas involved are small it is possible for normal bone cells or cartilage to replace the calcareous deposits after a very long time. However, when the disease is once established

within or near a joint its usual course is that of extensive destruction and absorption of bone and cartilage. As a result of this absorption bone areas once rather widely separated are brought in contact by removal of intervening cartilagenous structures. Once contacted, bony union may occur and firmly immobilize the joint and protect it from further injuries, permitting nature's plan of healing to progress undisturbed even to the point of complete eradication of the disease.

The happiest sequence in any tuberculous joint is complete fusion whether it be consummated by prolonged immobilization or by operative procedure. Early recognition and immediate treatment are imperative for minimizing the disease and preventing massive destruction. It is the advanced, neglected case in which deformity is gross and function greatly impaired.

Our greatest problems are with hips, spines and knees, and since the plans of their treatment are so different each will be discussed separately later.

#### **General Hygienic Treatment**

The ideal method of treatment is by prolonged hospitalization, extending over a period of years. Unfortunately expense limits hospital treatment even of private patients, and in charity institutions facilities are always limited.

Heliotherapy is undoubtedly of wonderful therapeutic value in bone tuberculosis. The skin develops an unlimited tolerance for the

\*Read before the Augusta (1924) meeting of the Medical Association of Ga.



sun's rays when the time of exposure is gradually increased.

Rest, food rich in vitamins, fresh air, cleanliness, contentment and happiness are all factors of importance and each essential.

### **Tuberculosis of the Spine**

We do not think it wise to have a fixed plan for treatment of tuberculous spines but rather to vary the procedure as indicated in each individual. At some of the best clinics very prolonged recumbency in plaster of Paris shell is the fixed routine procedure. Elsewhere spine fusion operation is performed without previous recumbency.

In younger children we are usually conservative and continue recumbency on Bradford frame or plaster shell over a long period of time, and later proceed with the spine fusion operation.

Children five years of age, or older, are first placed on Bradford frame and given general hygienic treatment, and kept in the open air and sunshine until their general health has reached its optimum. At this time spine fusion operation is done.

The Hibbs' operation is undoubtedly the best of all spine fusion procedures; however, other methods and modifications of the Hibbs' operation are employed, with good results. . . . As a result of spine fusion operation, superimposed spinous processes, laminae and articular facts are converted into a solid column of bone, immobilizing that portion of the spinal column and protecting the diseased vertebrae from further crushing injury and deformity. As a result of this complete immobilization the bodies of the diseased vertebrae are permitted to heal and frequently become fused to adjacent vertebral bodies, giving additional support to the impaired spine.

Spine fusion operation should be undertaken and planned with greatest consideration of operative safety to the patient. In young children and weaker patients the procedure should be so simplified and performed so dextrously that a minimum of time be required to complete the operation, and without shock. Carefully executed it

may be considered a simple and safe procedure.

About two months after a complete spine fusion operation the patient may be out of bed, wearing for a while a brace for additional protection.

These patients must live most hygienic lives, have systematic rest, sleep and nourishment during a number of subsequent years. They must remain under observation, and if necessary, be readmitted to hospital for heliotherapy and rest. Co-operation of a wise parent often makes a difficult problem an easy and successful one.

### **Tuberculosis of the Hip**

It is impossible to determine accurately the nature of every every case of hip disease without time and study. Regardless of whether it be of tuberculosis or pyogenic etiology, immediate immobilization of the hip is indicated, either by means of a plaster of Paris spica or rest in bed with traction. . . . X-ray pictures in the early stages do not always reveal the nature of the disease. In eliminating foci of pyogenic infection, tonsillectomy is a routine measure in all cases of hip disease. In younger children differential diagnosis is even more difficult. After a thorough study of the case, if any doubt remains, the hip is treated as if it were tubercular.

In the acute stage the hip is frequently excruciatingly painful and usually the suffering patient holds the hip acutely flexed and adducted. This type of case requires gentle traction with very gradual correction of the flexion-adduction deformity. The Bradford frame adds greatly to the comfort of such a patient, obviating the necessity of moving. When the acute inflammation has subsided a plaster of Paris spica cast is applied from the axilla to the toes with the affected extremity in abduction.

The onset in other cases is so insidious and mild that symptoms are of vague and indefinite character. Often the discomfort is not referred to the hip, and the origin of the pain and lameness is obscure. Traction in this type of case is not necessary, but a spica cast should be applied instead.

General hygienic treatment is as important here as in cases of pulmonary tuberculosis and is carried out in a similar way, except that recumbency may be discontinued when the acute inflammatory process has abated. When the progress of the disease has been arrested a spica cast extending to the knee may be worn. . . . One cannot emphasize too strongly the importance of keeping the diseased hip in the optimum angle of abduction and extension of the best function. The extremity should be held in this attitude by means of plaster spica casts.

In adults tuberculous hip joints frequently do not fuse even after prolonged immobilization. Here fusion by operation is indicated and can be successfully accomplished by means of a clear cut and well planned operation. Cartilage is removed from the head of the femur and a portion of the acetabulum. Bone to bone contact is obtained. To insure the success of the fusion bone shavings are packed into the spaces between the head and acetabulum to make bony contact greater and callous formation easier.

### **Tuberculosis of the Knee**

Plaster casts for immobilization and conservative measures have been the usual plan of procedure. Recently we are beginning to regard a fused knee as better than a partially healed tuberculous one which is unsatisfactory functionally, and a source of future possible inflammation.

Fusion of tuberculous knees seems to us as logical a procedure as fusion of any other joint, and undoubtedly it is not a radical viewpoint to assume that all tuberculous joints are better fused.

The erasure of the knee joint is accomplished by removal of all joint cartilage by means of a sharp chisel. Bone shavings may be employed and the patella may be denuded and implanted as a bone graft. Even after this operative procedure solid bony union often does not occur a number of months, or a year. During this time a plaster cast or brace is required. . . . The presence of caseous tuberculosis tissue

and tuberculous pus is not a contra-indication for proceeding with the operation.

### **Summary**

(1) Early recognition and immediate treatment are essential for prevention of massive destruction and deformities.

(2) Immobilization is absolutely necessary for healing of bone and joint tuberculosis.

(3) Fusion of tubercular joints insures permanent healing of the disease.

(4) Spine fusion operation should be done in almost every case of tubercular spine.

(5) Tubercular hips and knees should be fused in a position to give the optimum functional results.

(6) Hospitalization of many months facilitates the treatment of this disease.

(7) Heliotherapy and general hygienic treatment play a great part in healing tuberculosis of bone.

## **SURGERY OF THE THYROID GLAND UNDER LOCAL ANESTHESIA\***

**T. C. Davison, M. D.,  
Atlanta, Ga.**

It is not my purpose here to enter into a general discussion of goiter. We wish to show that in the majority of instances the diseased thyroid gland may be removed satisfactorily under novocaine anaesthesia, and that it is a safer procedure than its removal under a general anaesthetic.

We have a case of highly toxic goitre occasionally, in which it is advisable to administer a light gas-oxygen anaesthetic in conjunction with the novocaine anaesthesia. In thyroid surgery, as elsewhere, the anaesthetic must be selected which is best suited to that individual case. The success of any operation under local anaesthesia depends largely upon the ability of the operator to win the complete confidence of his patient.

We have used local anaesthesia almost exclusively in thyroid operations for several years, the only exception recently being a case of a child six years old with an ex-

\*Read before the Augusta (1924) meeting of the Medical Association of Ga.

\*On account of lack of space 3 cuts are omitted. They will appear in the author's reprints which may be had on request.

ophthalmic goitre. In this case we used novocaine anaesthesia combined with a light gas-oxygen anaesthetic.

If, while operating under novocaine, the necessity arises to supplement it with gas-oxygen, it must not be considered that the use of local anaesthesia is a failure. It is still an advantage in blocking the afferent nerves, thereby preventing shock. This is in accord with Criles' statement, that "General anaesthesia does not cut off the painful afferent impulses to the central nervous system, but only inhibits their physical interpretation."

It is most essential to be familiar with the minute anatomy of the operative field when using local anaesthesia, as you are injecting a fluid with a long needle into structures which are beyond your field of vision. It is especially true in the neck, where there are so many important structures in close relation, and in the case of an enlarged thyroid these normal relations are changed. A favorite expression of my well esteemed former professor, Dr. W. P. Nicolson, Sr., stresses well the intricacy of neck surgery. "Compared to surgery of the neck, abdominal surgery is recreation."

Extreme cases of thyrotoxicosis should be handled with great care, for, as Sistrunk says: "With each crisis the damage to vital organs, especially the heart, liver, and kidneys, increases until the patient finally suffers more from the symptoms produced by these degenerative changes than from the disease itself." In these cases, the extra burden imposed on the already impaired vital organs by a general anaesthetic must be viewed with a due sense of its seriousness.

The degree of toxemia in every thyroid case is determined by a basal metabolic reading, the vital organs are examined carefully for any evidence of degenerative changes, and then the course of treatment is planned accordingly.

Patients with a high metabolic rate should not be subjected to a radical operation. A single or double ligation of the superior thyroid arteries should be performed under local anaesthesia, which reduces the tox-

emia. Later a partial thyroidectomy must be performed.

The basal metabolimeter is more important in estimating the degree of toxicity in goiter than is the clinical thermometer in determining the temperature in a case of pneumonia. It is an accurate index to the toxicity, and the degree of toxicity determines the type of operative procedure.

The chief dangers of general anaesthesia in thyroid surgery are:—

1. Post-operative pneumonia.
2. Over-taxing the heart.
3. Over-taxing the kidneys.
4. Shock.
5. Injury of the recurrent laryngeal nerves.

In addition it might be said that the excitement incident to the induction of a general anaesthetic is often greater than that which attends operating under local anaesthesia.

The advantages of local anaesthesia are:—

1. Dissection of the skin flaps may be performed more easily and more quickly, owing to the infiltration of the subcutaneous fatty tissue with solution.

2. There is less hemorrhage, due to the lack of venous engorgement that accompanies general anaesthesia.

3. Local anaesthesia enforces gentleness in handling the tissues, which is most important in thyroid surgery, as excessive manipulation of the gland will cause increased toxemia. The average operator will unconsciously handle tissues more roughly under general anaesthesia.

4. By conversation with the patient, the operator has a constant check on such exhaustion producing factors as pressure of instruments on vital structures of the neck, which cause discomfort, if not direct embarrassment of respiration and circulation.

5. Injury to the recurrent laryngeal nerves should rarely occur in local anaesthesia. The operator, conversing with the patient, can know at once by hoarseness in the patient's voice when these nerves are compressed or otherwise traumatized.

6. Post-operative nausea, vomiting and





Infiltrating the subcutaneous tissues with  $\frac{1}{2}$  of 1% solution of novocaine using a Dunn automatic syringe

strangling, with the attendant risk of hemorrhage are practically eliminated.

7. The patient can take liquids by mouth immediately after operation, which eliminates the necessity of proctoclysis, a procedure always irritating to excitable patients.

#### Technique

A preliminary hypodermic of morphine and scopolamine is given one hour before the operation is to begin. A piece of moist gauze is placed over the patient's eyes outside the operating room. This is done with the object of concealing from the patient the necessary activities in the operating room, although the patient is told that this is to protect the eyes from the strong light.

The staff of assistants are instructed not to talk, and to make no unnecessary noise, such as rattling of instruments, etc. The patient is placed on the operating table with a sand bag under the neck, thus allowing the head to be extended. This makes the

operative field more prominent and accessible. The table is placed in the "goitre position," on a plane of about thirty degrees, head up and feet down. It is essential to make the patient comfortable before the operation is begun, otherwise the patient may become restless, thus interrupting the operation.

The field of operation is prepared and draped. While the operator talks to the patient in an even tone of voice, the gland is handled gently, the skin is pinched between the thumb and index finger, and a small hypodermic needle is quickly inserted. One half of one per cent solution of novocaine is used to infiltrate the skin across the front of the neck in line of the proposed incision. Then a larger and longer needle is used in connection with a Dunn syringe, which gives a continuous flow without the necessity of withdrawing the needle. The subcutaneous tissues are thoroughly infiltrated. This also facilitates the dissection



Making the skin incision and dissecting the flaps.

of the skin flaps. The anterior jugular veins are clamped, cut and ligated. A special spreading, self retaining retractor is used to hold the skin flaps. The sterno-thyroid and sterno-hyoid muscles are separated in the median line, exposing the thyroid gland.

If the goiter is large, and the muscles interfere with its delivery, special clamps are applied across, and the muscles incised. This facilitates matters greatly in difficult cases, though it is not always necessary. When the gland is thus fully exposed, all four of the poles are injected, care being taken not to injure the large vessels of the neck.

The method of procedure may vary at this point, depending upon whether the conditions require a lobectomy or a partial bilateral thyroidectomy. Removal of the gland is begun at the lower poles, and gentle traction upward is made with Allis clamps, as the vessels are clamped and cut. The major portion of the gland is removed, the

posterior capsule and a portion of the gland attached being left.

While removing the gland, the operator engages the patient in conversation, to detect any pressure on, or injury to, the recurrent laryngeal nerves, which is manifested by a huskiness or hoarseness in the patient's voice. These nerves lie in direct apposition to the posterior capsule.

All vessels are ligated, and clamps removed. Thorough hemostasis being assured, the muscles are sutured in the median line with zero chromic catgut. A stab wound is made in the skin just above the suprasternal notch, and through it a small rubber tissue drain is inserted into the cavity to prevent hematoma formation. This is removed in twenty-four to forty-eight hours. A continuous suture of number zero chromic catgut is placed in the subcutaneous tissue and fascia, to prevent spreading of the scar, and the skin is closed with horsehair sutures. The wound is covered with dry gauze, and

## ADHESIVE BANDS OF ASCENDING COLON, WITH OBSTRUCTIVE SYMPTOMS\*

L. W. Grove, M. D.,  
Atlanta, Ga.

In selecting a title for a discussion of this subject, we have purposely digressed from the more common terms, descriptive of abdominal adhesions, using the title "Adhesive Bands of Ascending Colon, with Obstructive Symptoms;" wishing, in the beginning, to establish this as a definite clinical entity, having a definite pathology, which is manifested by more or less constant symptoms.

During the last four or five years, we have been impressed by the increasing number of patients, who have been operated on for so-called chronic appendicitis, who had not been relieved of their symptoms, and in some of these cases, following a critical study, it has been found that the pathology still existed in the right colon.

Lichty, in discussing chronic appendicitis, states that he believes that not more than 60 per cent of cases with a diagnosis of chronic appendicitis per se, are justifiable clinically. Coffey, of Portland, Oregon, in a recent report, stated that 70 per cent of cases studied in his clinic, who had been operated for chronic appendicitis, elsewhere, had not been relieved of their symptoms. Following a critical analysis of his operative findings in this group of cases, he found that in fully 20 per cent of these, failure to relieve, was directly due to the fact that this condition of the ascending colon was not recognized and suitably dealt with, at the primary operation. This he attributes largely to incomplete pre-operative study and inadequate incisions, with incomplete exploration.

Unfortunately the medical profession is given to fads, and as it has occurred in the development of the treatment of gall bladder disease, gastric ulcer, displacement of the uterus, goiter, etc.; it is equally true of chronic appendicitis. It has taken years to select the sound from the unsound teaching

\*Read before the Medical Association of Georgia, May 7-9, 1924, Augusta, Ga.



A figure of eight bandage is applied using a "goiter roll," which gives security and stability to the wound

a figure of eight bandage applied around the neck and chest, to hold the dressing and support the neck.

We have tried regional blocking of the cervical nerves at their exit from the spinal canal, but prefer the infiltration method as described.

The use of local anaesthesia is a great relief to many patients, who often admit that what they mostly dread in operations is the general anaesthetic.

## SICKLE CELL ANEMIA IN NORTHERN NEGRO

R. Allyn Moser and W. J. Shaw, Omaha (Journal A. M. A., Feb. 14, 1925), report a case of sickle cell anemia occurring in a negro who was born in northern Kansas (Leavenworth), where he resided until 8 years ago, and since then he had lived in South Dakota. He had never been South.



of the enthusiast, in fact, the entire advance of medical science has been made in this way. It would appear that a hurried unfinished technique and misrepresentation of post-operative results, have all too often triumphed over the painstaking and faithful individual. We have come to believe that a more thorough exploration, based on a profound knowledge of anatomy and pathology, with a careful and more complete report of the post-operative course, would do much to improve our operative results, in abdominal surgery, and would aid materially in educating the profession. It also appears, that the surgery of the future will demand a more thorough knowledge of embryology, physiology and pathology with a more careful and finished technique. As recently emphasized by Horseley, there is no field of surgery, demanding a closer interweaving of these biological principles, than abdominal surgery.

### Etiology

Despite the great volume of experimental work that has been done, (mostly foreign), in an effort to determine the exact cause of these adhesive bands, their etiology is still unsolved. There are those investigators who have taught that they are congenital, resulting from a partial and improper rotation and fixation of the cecum and ascending colon. Conspicuous among the advocates of this theory have been M. L. Harris, Jackson, Durett, and more recently Willis Westmoreland and C. W. Strickler. It has been estimated by Wilhms and other like authorities that this abnormal position of the colon occurs in approximately 20 per cent of supposedly normal individuals.

There is a second school which has taught that these bands are compensatory, simply an effort on the part of nature to suspend or to support a too mobile cecum and ascending colon, which has resulted from an improper rotation and fixation of the cecum and ascending colon. Conspicuous among these investigators have been Wilhms, Sir Arbuthnot Lane and Coffey, of Portland, Oregon.

There is still another school which has taught that the bands are simply a part of an inflammatory process, the result of a pericolicitis, occasioned by a long continued cecal stasis.

In the management of these cases we have assumed that the condition is congenital, basing our assumption largely on the structure of the bands and the fact that the condition is often seen in early life. Indeed some of the worst cases have been noted in young children.

### Pathology

The condition found at operation is constant, merely differing in grades of severity, of the lesion. In the first and the most common condition found there is either one large fan-like band or multiple smaller bands which occur at the junction of the lower and middle third of the ascending colon extending up the colon to variable distances. These are attached to the parietal wall and extend over to involve the ascending colon. As a result of this band or bands there is a definite constriction with angulation at the point of attachment, and as can readily be understood the constriction is necessarily aggravated or increased during peristalsis. With the point of attachment of the bands acting as a fixed point during contraction of the bowel, there is an increased rotation resulting in an increased constriction of the intestine. The right sided pain which is so characteristic of this condition is probably caused by this increased peristalsis.

The second condition found is merely an extension of the pathological process described. Here we have the band extending to involve or grasp the ascending colon. As a result there is added to the first condition a second point of constriction which occurs at the hepatic flexure. This is produced by fixation of the transverse colon to the ascending colon, and results in an acute angulation at the hepatic flexure.

It is to be noted that the construction, of these bands, also supports the idea that they are probably congenital, by the reason of

the fact that they are poor in blood supply, and are not adhered to or a part of the peritoneal covering of the colon. When they are divided they strip back freely and leave few or no bleeding points or raw surfaces. It would appear that if the condition was the result of an inflammatory process, there would be definite areas of adhesions resulting in raw surfaces, when the bands were removed, or stripped back. This does occasionally occur, but it has been our experience that it is more often due to rough manipulation rather than to definite adhesions.



Slide No. 1—Shows packed condition of cecum with an associated dilated terminal ileum with retention

### Symptoms

The symptoms are briefly those of a low partial or chronic obstruction, characterized by pain in the right lower abdomen which is aggravated by any unusual exertion or exercise or when the patients are constipated and the colon is not emptying freely. There is associated in a certain per cent of cases, by no means the larger number, the picture of ptosis. This is characterized by the rounded shoulders, flat chest, prominent abdomen, etc., accompanied by the

numerous systematic manifestation. Conspicuous among these is often noted loss of weight, headache, anorexia, little or no desire for food, especially breakfast, hypotension, cold clammy hands and feet.

The physical findings relative to the abdomen are most often a generalized spasticity, especially marked over the right abdomen, which is intensified on pressure. This is associated with some generalized tenderness, with evidence of considerable accumulation of gas.

These symptoms accompanied by the char-



Slide No. 2—Shows packed condition of cecum and ascending colon which persisted for three days

acteristic X-ray findings are sufficient for a diagnosis. On fluoroscopic study we invariably find a dense cecal retention varying from forty-eight hours to four or five days, often accompanied by evidence of obstruction at the ileo-cecal junction, with retention in and dilation of the terminal ileum. Unlike the usual picture of retention, the cecum and ascending colon appear to be packed with bismuth. There is often also associated, evidence of a partial obstruction at the hepatic flexure. This is especially marked in the severe cases, in which the bands have extended to and involve the transverse colon, resulting in fixation between the ascending and transverse colon, with an acute angulation at the hepatic flexure. This is very easily demonstrated under the fluoroscope, when it is found that it is impossible to separate the transverse from the ascending colon, both being more or less fixed to the abdominal wall.

#### Technique

We have used, as routine, a right rectus incision deflecting the body of the muscles out to the outside, being careful to open the peritoneum well toward midline. We

think this is a very important step in the operation, as it brings the line of closure well toward the midline and away from the repaired peritoneal surface of the colon. This incision readily lends itself to a thorough exploration, as it can be enlarged at will, and at the same time preserve the nerve supply and insures a safe physiologic closure. We have discarded the McBurney's

incision, except in some cases of acute appendicitis in children. This type of incision is inadequate for a thorough and complete exploration, which we feel should be done in every chronic condition of the abdomen. After the abdomen is opened, a methodical exploration along definite anatomical lines is done. Being convinced that there is no other pathology present, these bands are carefully divided with a sharp knife and ligated at both points, with fine silk. At a last procedure the appendix is removed, if present. The surfaces are carefully inspected for bleeding points and abdominal cavity closed, being careful to evert peritoneum.

Following operation, these patients are given the usual post-operative care, with the exception of being kept in bed a longer period of time. At one time we advocated an early stimulation of peristalsis, by early purgation, but we have come to believe that an impaired intestine is entitled to rest, as





Slide No. 3—(a) Shows the most common form of bands. (b) Dotted lines show points at which bands are divided

all traumatized tissue is, and now these cases have their bowels moved by general purgation, usually an enema, on the third or fourth day.

Following immediate post-operative care, we have routinely placed these cases under the care of a competent internist for his supervision of their diet, exercise, etc. This is continued for an indefinite period of time.

In conclusion, we are convinced that this condition is often responsible for symptoms previously attributed to so-called chronic appendicitis and that in the carefully selected cases the procedure has a very definite place in surgery. As has been so well suggested by Dr. Everts Graham, "the future of all abdominal surgery lies not in unwarranted fads, prejudices or stereotyped operations but in a more careful exploration, followed by a more intelligent interpretation of the pathology found and suitably dealing with it."

53 Forrest Ave., Atlanta, Ga.

### AIR CYSTOGRAMS TO DEMONSTRATE PROSTATIC ENLARGEMENTS WHICH PROTRUDE INTO THE BLADDER\*

Edgar G. Ballenger, M. D.,  
Omar F. Elder, M. D.,  
and  
Wm. F. Lake, M. D.,  
Atlanta, Ga.

In a preliminary report we have previously drawn attention to the fact that enlargement of the prostate gland at the vesical neck may be demonstrated in a graphic manner by air cystograms.<sup>1</sup> Such X-ray plates afford considerable assistance at times when we are in doubt as to the method of procedure to follow in overcoming the urinary symptoms which are thought to be prostatic obstruction.

The part of the prostate gland with which we are often chiefly concerned in not that

\*Read before the Augusta (1924) meeting of the Medical Association of Ga.

which can be palpated through the rectum, but rather the intravesical portion which projects in a snout-like mass somewhat resembling the cervix of the uterus. Needless to say, such prostatic enlargements may be seen by cystoscopic examinations, but owing to the enfeebled condition of elderly men who are subject to prostatic obstruction, and at times for other reasons, cystoscopic examinations are not always advisable or feasible.

In patients who come in this group, information of definite value may be obtained by the air cystograms. The surgeon is assisted in deciding if an operation is necessary and whether the approach should be by the suprapubic or perineal route. Furthermore, the graphic demonstration of the cause of the patient's urinary difficulties and why the operation is needed become evident to him and his family and his decision to have it removed is more easily reached.

It is obvious, of course, that air cystograms are not required in all cases, for many times, the symptoms, residual urine and massive prostatic hypertrophy present a picture so definite that neither a cystoscopic examination nor a cystogram is required. On the other hand, there may be no reasons why the usual cystoscopic examination cannot be made, in which case cystograms are not necessary. Occasionally, however, there is found a calculus in a diverticulum which was not suspected and which was not seen during the cystoscopic examination. In order to prevent such an occurrence an X-ray examination is advised by some urologists as part of the preliminary routine.

The diverticula show when the bladder is distended with air, as with sodium iodid, etc.

We have seen one patient who could not be cystoscoped on account of urethral strictures, in whom soft phosphatic stones were not shown in the air cystogram and where calculi are suspected we advise that an ordinary X-ray picture be taken in order

that the longer exposure be given and the stone will thereby be more likely to be demonstrated.

One patient was seen who had a pedunculated median lobe and very small lateral lobes; the X-ray film gave us the slight impression that perhaps the shadow might be a stone instead of a median lobe, which we had not, heretofore, seen so well pedunculated. The cystoscopic examination and operation however, showed the shadow to be a median lobe only.

It is our purpose to take the picture at right angles to the long axis of the projecting mass. As far as we have been able to determine, we cannot show any of the soft tissues except those which project into the bladder cavity and are more or less surrounded by air to give the necessary contrast in density.

Pelvis tumors, however, which press on the bladder are shown clearly.

Considerable information may be obtained in determining the extent of the bladder involvement in cancer of the prostate and thus we may be enabled to advise the patient with greater precision as to the measures required to give the best results.

Unfortunately one of our most interesting plates was misplaced or lost and we cannot show you a slide of the carcinoma of the rectum which projected into the bladder mucosa. In addition to the air in the bladder, barium was injected into the rectum and sigmoid. The result as shown by the X-ray gave a very instructive and graphic demonstration of the extent and status of the malignant changes. The negative was given to the patient to show to the general surgeon who referred the patient to us to determine the extent, if any, of the bladder involvement, and so far we have been unable to find what became of the picture. We will show you though, a slide somewhat similar of a pelvic sarcoma in a boy six years of age, which was pressing on the bladder posteriorly but owing to a lack of control of the rectal sphincter it was not feasible to employ the barium and so it

shows only the air in the bladder and the tube in the rectum.

In view of the foregoing remarks, it will be seen that we do not advise air cystograms in every case but rather in those in which additional information is desired than that obtained in our usual examinations and in those in whom it is impossible to do a cystoscopic examination.

Comparatively little discomfort is produced by the air in the bladder in those patients who have residual urine and who are free from cystitis. On the other hand, the patients with stones in the bladder and those with a definite inflammatory condition complain considerably, at times, of pain while the air is in the bladder. This may be lessened, as may the discomfort from the passage of the catheter, by the employment of novocain, alypin, etc., in the urethra and bladder.

The older urologists may remember the bladder discomforts from air injections if in the early days of cystoscopy they used a cystoscope which was made for air inflation.

### Technic

As it is advisable to reduce the time of the discomfort to the minimum, all the preliminary preparations for the exposure should be made before the bladder is inflated.

The technic generally used is about as follows: The patient is given a cathartic, preferably castor oil, fifteen or eighteen hours before the exposure is made and a soap suds enema about an hour before. Just before the examination, he is requested to empty the bladder as completely as he can. He is then placed on the Bucky Diaphragm in the dorsal position; one ounce of a one per cent solution of novocaine or alypin is injected with a urethral syringe through the urethra into the bladder, withdrawing the residual urine, which is measured. The type of the catheter to be employed naturally has to be varied to meet the difficulties encountered in its passage. In our preliminary report on air cystograms in the Jour-

nal of the American Medical Association, we stated that a hard rubber catheter was used. This, of course, was an error, as we do not possess such a catheter and we are unable to explain how such a statement was incorporated in our paper or how we failed to see it in reading the proof. The catheter when passed is fixed in place with adhesive strips to prevent its slipping out as the patient turns over. A rubber band is placed around the penis to keep the air from escaping around the catheter.

The patient is now placed face downward directly in the center of the Bucky Diaphragm, care being taken that he is flat and that the spine is straight. The buttocks are separated as far as possible and sufficient compression is made with the canvas band to hold them apart. A Murphy drip, loosely packed with sterile cotton, is connected to the tubing. This is for the purpose of filtering the air injected into the bladder, but we rather doubt whether it is at all necessary. Air is then injected into bladder with a bulb or piston syringe until the inflation causes some discomfort, or about as much air as 100 cc syringe will hold. The amount tolerated by the patient depends, as previously stated, on the degree of cystitis or presence of calculi and upon the over distention produced by the residual urine. The patients bear it best who have the largest amount of residual urine.

The roentgen-ray machine, having been previously set, and the tube adjusted with a 20 degree angle so as to direct the rays upward through the pelvic ring, the exposure is made. The air is allowed to escape through the catheter which is then removed.

The time of the exposure and the penetration is largely a matter of judgment much as in demonstrating the kidneys. With medium size patients, the best results were obtained with a 3½-inch spark gap, 20 milliamperes and ten seconds, using superspeed films. With large patients a 4-inch gap was used.

It should be borne in mind that the object is to show a shadow of soft tissues in a me-



mium of air, and that over exposure will impair accurate results.

(1) A. Hyman also in 1914 made a report on the same subject as did a German surgeon several years before this.

DISCUSSION ON PAPERS OF DRS. LAWSON THORNTON, ARCH ELKIN\*, T. C. DAVISON, L. W. GROVE and E. G. BALLENGER

DR. W. F. LAKE, Atlanta: Discussing Dr. Ballenger's paper, from the radiographic standpoint the primary object was to see if we could determine the size and shape of the prostatic shadow, and in doing so we could not only determine with fair accuracy the size and shape of the prostate, but we could determine also the size and shape of the bladder wall, such as thickening of the musculature, diverticula, the existence of tumor, any involvement of the bladder wall, and so forth.

To my mind, as an X-ray man, these cystograms would serve the urologist in two different ways. First, as a valuable adjunct to the cystoscope to confirm what he saw, or what he thought he saw, in the cystoscopic examination and, second they would serve as a definite diagnostic agent in those cases where cystoscopic examination is not advisable or feasible. In those cases it seems to me the air cystogram will give information which is not obtainable in any other way. There are patients who give a definite history of prostatic disease but rectal examination fails to reveal enlargement in accord to the symptoms given by the patient. In those cases the urologist obtains a fair knowledge of what the prostate looks like by means of the film. We have followed many of these cases to the operating room and have made pathologic sections in many of them after tumor has been removed, and it has been our experience to find that the actual tumors of the prostate correspond to the interpretation of the cystogram.

DR. WILLIS F. WESTMORELAND, Atlanta: The paper I am really interested in is Dr. Grove's. I think it is very unfortunate that we ever got connected with this subject. In my experience these are all embryologic conditions. As the colon goes across the hepatic flexure it follows the ascending colon and grows down. At that time the small intestine enters from the right, and as the colon grows down it must rotate on its own axis. In that rotation the colon carries these adhesions, as they are called, across with it and the effect upon the patient depends upon how many of these have been picked up and upon how thick they are.

Another condition is the ileocecal fold which goes down and forms the mesentery of the appendix. If that appendix is ligated en masse, that is, the mesentery is ligated en masse, the trouble is increased instead of decreased and that patient will always suffer more after the operation than before, because the operation has increased his difficulty. I have been operating on these cases for about seventeen years and with one single exception I have never found one case that did not have trouble at the hepatic flexure. As it picks up the pole of the mesentery coming across it frequently has brought together the transverse and the ascending colon, forming an acute angle at that point. Again, we find that the omentum

goes clear across the colon and the end of the omentum blends with the hepatic flexure, sometimes producing a decided constriction of the gut. If these are not corrected the patient will not make a recovery. I am inclined to believe that where we have these conditions at the upper end of the colon the patient suffers more than when they are at the cecal end. He will never be a well patient until this is corrected. He may be improved but will always have relapses.

I think the reason this condition has not been recognized early is due to the McBurney incision, which I have always thought illogical. A small incision and quick work—an inch and a half incision and a week and a half in bed. You cannot do them that way. Whenever a man says he removes an appendix in twenty minutes, or forty or forty-five minutes, I know he has not done the proper work. When can he do it through a small incision? Because a man makes a small incision and puts his finger in and hooks up the appendix and calls it the whole thing is one reason why so many patients have so-called chronic appendicitis and suffer more after the operation, because this trouble is increased by the mechanical effect of the operation. You must have a free incision, see what the condition is and correct it properly. When a surgeon comes in contact with a retroverted appendix—I have seen surgeons operate through these small incisions and the portion of cecum they pulled out through that small opening was as blue as indigo from the constriction. These patients frequently die from the mechanical violence that the surgeon has used. If the incision is increased about an inch one can pull out the colon and not injure it. My rule is to keep on increasing the incision upward until I can turn the whole colon over, and then the appendix is between the peritoneum and the gut and I can operate without any trouble. It is important to do this when one is operating on an acute appendix in this condition.

DR. R. M. HARBIN, Rome: I think Dr. Grove has brought a very important question here for consideration.

I rise to take issue on a statement Dr. Grove quoted from Dr. Coffey. He said that 70 per cent. of the patients operated for chronic appendicitis do not get relief. That may be due to bad surgery or incorrect diagnosis but my belief is that either the statistics are misleading or the diagnoses are wrong. We have recently reviewed some cases with that point in view. Out of five hundred laparotomies where the diagnosis was in question there were one hundred and ninety-one elective operations and of these sixty-five were classed as chronic appendicitis; that is, where no pathology was to be detected other than of the appendix. For purposes of diagnosis by elimination the right rectus incision should be used in the elective operations. I think we all agree about that. There is no way to follow up a correct diagnosis except by a subsequent clinical record. We wrote to these sixty-five patients and received forty-four replies. Out of these, the great majority claimed to be partially if not entirely relieved. Thirty-three reported that they were well and had no more of the trouble for which they came for operation. Of course, that is not enough statistics to prove anything but it offers a suggestive value that we might expect more than 50 per cent. of cures after a conscientious diagnosis. We have to rule out many collateral pathologies to arrive at correct diagnosis.

The appearance of the appendix is not an index to the relief one is going to get from its removal. We may find grossly pathologic appendices during an

\*Dr. Elkin's paper has not been received by the Journal.

operation for something else, the patient never having given symptoms that might be referred to the appendix, and in other cases, we may find an appendix that looks innocent and in such cases the patient gets a 100 per cent. cure. Some may say "psychology," but that theory will hardly stand that test of a follow-up history.

I wish to emphasize another point, that the question of chronic appendicitis has been viewed with dogmatic scepticism but it certainly requires all the skill we have to make the diagnosis by ruling out collateral pathology, and then if operation is decided upon the improvement and recovery from symptoms greater than is generally believed.

DR. J. S. DERR, Atlanta: Dr. Davison mentioned a case of carcinoma of the thyroid which he referred to me for treatment. I gave the patient three hours exposure, using in all, 5 m. a. K. V. with 5 m. m. copper and 2 m. m. aluminum filter. Number of treatments 3. This was sufficient to produce thorough bronzing of the neck. That was a year or more ago and the patient has had no recurrence.

I wish to commend the work of Drs. Ballenger and Lake on the prostate. I think this work is very well worth while and I have done a little of it. Dr. Amance Granger, of New Orleans, recommends oxygen instead of air because he says the bladder irritation is much less when oxygen is used.

Dr. Grove's paper was very interesting, especially in regard to the appendix. I do not believe that the diagnosis of chronic appendicitis is as much of a chimera as some surgeons have tried to make it out. I think that X-ray observation is one of the best diagnostic adjuncts we have. I have diagnosed these cases repeatedly in this way, have seen the patient come to operation, and have seen the patient relieved. Not every patient sent to the roentgenologist for diagnosis has to have a diagnosis of appendicitis.

DR. J. L. CAMPBELL, Atlanta: I have been studying the condition discussed by Dr. Grove for the last few years and the more I think about it the more interested I become. Whatever the cause may be, whether it is embryologic or chronic stasis from gastro-enteroptosis, as claimed by Coffey, or to a low grade chronic infection. One fact is outstanding in the vast majority of cases, the lesions and the symptoms are on the right side of the abdomen. Coffey has called attention to certain points of fixation. One at the pylorus, which is fixed most firmly to the under surface of the liver; another where the duodenum is attached to the posterior wall of the abdomen; a third at the duodenal junction; a fourth at the ileocecal junction and lastly, the whole ascending colon. With these points of fixation firmly impressed upon our minds we must simply make a careful search to find and relieve the pathology. Whether it is a Jackson veil, which I believe in the majority of instances is embryologic or a Lane kink, which may also be embryologic, postoperative adhesions or adhesion, the cause of which cannot be definitely determined. The symptoms are frequently those of chronic appendicitis.

We also want to remember that there is a normal ileocecal membrane which runs for a variable distance up the ileum and across the cecum to the appendix so that when this structure is put on the stretch by a distended cecum a kink at the lower end of the ileum is produced which may cause a considerable amount of obstruction. If one operates and does not remove this membrane, the object of the operation is often defeated. The Jackson veil can be easily removed, as Dr. Grove has shown in his lantern

slide, but it must not be drawn up and ligated en masse, especially at the point of attachment to the intestines or again the object of the operation will be defeated.

As Dr. Westmoreland brought out, there are frequently bands of adhesions that pass from the gall bladder and cystic duct, over the colon and produces a partial obstruction which may cause intense pain simulating gall bladder disease. Again we have adhesions passing over the colon as shown by Dr. Grove which give even greater trouble, because they prevent the churning motion of the gut and cause the retention of the food material and allow a more complete absorption of the fluid, with the contained poisons and toxins thus producing various remote effects upon the organism.

DR. GEORGE C. MIZELL, Atlanta: I wish to thank Dr. Grove for his explanation of the title of the paper as given in the program. To me it appears unfortunate that it is becoming unpopular to make a diagnosis of chronic appendicitis. Such a diagnosis is falling into disrepute among both internists and surgeons. This is brought about by the fact that so many patients have had appendices removed without good results. We must study this situation from all angles.

Doubtless you will recall McGarrison's very excellent paper published a few years ago in the Journal of the American Medical Association, in which he reported a study of abdominal diseases in connection with the habits of the native of upper Egypt, Nigeria and other similar civilized tribes. He found that these people did not have the abdominal diseases that are found in civilized races, and he expressed the opinion that freedom from these diseases is due to diet and habits. This appears to raise the question as to whether congenital bands are ever the source of trouble until they are associated with infections of the gastro-intestinal tract. We know that bands very seldom give trouble until the patient approaches adult life, and when they do give trouble it is almost invariably after a distinct, acute, inflammatory attack, so we have brought into the subject the question of infections of the gastro-intestinal tract.

Regarding chronic appendicitis, it may be said that, in my observation, it is the most common infection and is the most common source of trouble in the right side of the abdomen. When it is present, for any length of time, there results always a chronic colitis, perhaps a chronic gastric and duodenal ulcer, or an infection of the biliary passage and liver. Furthermore, as a result of infections of the colon, adhesions and bands in the right side of the abdomen may result. In my opinion, chronic infection of the appendix is beyond medical measure—hence always a surgical condition.

As Dr. Grove and Dr. Westmoreland have stated, it cannot be made too clear that proper exploration cannot be made through a small incision. The proper procedure is to make a large incision, remove all of the surgical pathology and then recognize that there is an abnormal gastro-intestinal flora that must be taken care of after operation.

DR. CHARLES E. WAITS, Atlanta: Discussing Dr. Davison's paper—

Local anesthesia has contributed very materially to the advance in surgery of the thyroid gland during the past decade. For some five years we have used with satisfaction either straight local, or a combination of local with nitrous oxide in all of our thyroid work. In dealing with the non-toxic adenomatous and col-



loid growths where the patient's composure is good local anesthesia finds its most useful field.

In the exophthalmic group and the toxic adenomata we believe it is better to associate with novocaine a light nitrous oxide anesthesia.

These patients are very apprehensive and any measure which will lessen the psychic shock incident to operation, we believe will contribute to the safety of our operative procedure.

Concerning drainage in these cases, we have tried numerous methods and have come to feel that drainage through a stab wound in the supra-sternal notch is best. This, however, has one objection. There will occur not infrequently an adhesion at the point of drainage, which on deglutition produces a dimple and slight pulling on the trachea. We have been unable to overcome this objection in all cases. We believe that all cases ought to be drained.

One other difficulty which we have been unable to overcome entirely is the accumulation, about ten days after operation, of serum in the line of incision. This happens often regardless of the kind of suture material used.

DR. ARCH ELKIN, Atlanta (closing on his paper): The material that I gave the report from this evening was all from our Good Samaritan Clinic, and this month they have put in a laboratory and X-ray equipment, that, so far as we know, is as complete an equipment as any clinic can have. As I told you, this clinic is purely charity. In addition to that we have a photographic department in the clinic, have the best lens obtainable with a clinic camera, and we not only invite the Association to send charity patients to us for examination and diagnosis, but we also would be very glad to photograph any specimens from cases which you will send us, of course, without any charge.

DR. T. C. DAVISON, Atlanta (closing on his paper): I wish to stress the point that in giving iodine to goiter patients we must select our cases. It is a good thing but it must not be given promiscuously. The negro boy we showed you worked for the (35)—three S company. He had been taking the S. S. S. medicine, which is very rich in iodine, and he blew up and had a very acute thyrotoxicosis. After ligation his basal metabolism reading went still higher and then quieted down and he got so much better that he refused to come back for further treatment. In these cases the basal metabolism is just as important as the thermometer in fever. We use a chart with everything charted out and anything above 10x is toxic, or hyper—anything below —10 is hypo, and we use this test to determine the condition of the patient and the indications for treatment. I wish to give you four indications for thyroidectomy.

First, you get some cases in which the goiters are so large that they are unsightly and the patients wish to have them removed for cosmetic reasons.

Second, there are distressing pressure symptoms in many cases. I showed you some of those that produce pressure symptoms on the nerves, trachea or other organs in the neck.

Third, in the thyrotoxicosis. In any toxic goiter operation is indicated, provided the patient is not in too bad shape to do a thyroidectomy.

Fourth, any patient who is past mid-life and who has a goiter which begins to grow suddenly or rapidly, should always make one suspicious of malignancy. I have had five cases of malignancy in three years. I showed you three of them tonight. If the

goiter is circumscribed it may be removed safely, but if it has broken through and gone into the adjoining structures of the neck the only thing you can do is the decompression operation, if that is indicated, and give X-ray irradiation.

DR. L. W. GROVE, Atlanta (closing): Gentlemen, I am especially grateful for this nice discussion. It proves that the right abdomen is still very active. I know of no one better qualified to discuss the subject than Dr. Westmoreland. He brought out this morning in his paper and in his discussion a great many points that have not been written much about. I am sure nobody is better qualified to make statements than he is, for he has done so much work on the subject.

Dr. Harbin's point I think is well taken. I do not think this paper has any fight on a legitimate chronic appendicitis. Dr. Eastman, of Indianapolis, wrote a very timely article some months ago entitled "Is Chronic Appendicitis a Myth," in which he took to task the point that everybody was having chronic appendices removed. We unquestionably have a chronic appendix and if we are not careful we will overlook some of these cases and have unnecessary mortality. However, I am sure that we are all seeing cases every day in which operations have been performed in these cases and in which the patient is just as bad, if not worse, than before the operation. I think Coffey's figures might be explained in this way, I, too, thought they were rather high, but I think he gets the worst cases, the desperate ones, and for that reason his 70 per cent. of non-cures following operation for chronic appendicitis probably would not apply to cases at large.

In reference to Dr. Harbin's remarks, we must remember that he examines his patients just as we would like to, but we must also remember that these cases represent patients with no neurologic investigation, and probably some of them with very little clinical investigation, and that probably explains the point he made there.

As to the cause of this condition, as I said, we probably are not sure about it. I think it is congenital. While we see most of them in adult life we do see them in children, and if we go into the history carefully enough we still find a history of gastric distress early in life.

Dr. Harbin also brought up the point that many cases of appendicitis do not show symptoms. I think that is true, but many cases will show symptoms of this condition. The physical findings are, briefly, these: A generalized stiffness of the right abdomen, and if we palpate these people we will find a tenderness which is quite marked and we invariably can feel the gas slipping through this constricted area.

Dr. Mizell has emphasized a point I tried to make. I think it is a mistake to operate on any of these cases and turn the patients loose. They should be sent back to the internist and carefully supervised until they are back to a normal state.

In closing, I think we should emphasize a point in relation to this condition. The right abdomen has, and will continue to, if we are not careful, been opening up a great field for unnecessary surgery, but I am also unconvinced that if cases are carefully worked up and a careful differential diagnosis is made that we cannot cure many of these people who have probably had their appendix out but are worse off than before the operation.



**ECLAMPSIA\***

**W. L. Mathews, M. D.,  
Winder, Ga.**

Some cynical member of the medical fraternity has amiably observed that "the less we know about a disease, the more we talk about it." He must have had eclampsia under discussion, for, although we know almost nothing about it, at least in its origin and etiology, we are always talking and writing about it—about what we know and what we don't know, what we think we know and what we know we don't know. I venture to say that, proportionately to the number of patients concerned, tuberculosis is the only disease that outdistances eclampsia in the number of books and papers and articles published about it. This is not at all surprising to be sure, because so long as there is something yet unknown, medical scientists will continue their investigations in the pursuit of knowledge of all the diseases that trouble the human family.

Eclampsia has been defined by Williams (Johns Hopkins, 1917) as "an acute toxemia occurring in a pregnant, parturient, or puerperal woman, usually accompanied by clonic and tonic convulsions, during which there is loss of consciousness followed by more or less prolonged coma, and which frequently results in death." Most of us, I dare say, do not require a definition to be able to recognize a case of eclampsia when we encounter it in general practice. The "lightning-like suddenness" of the attack," like a bolt from the blue" in women who are apparently in perfect health, its much greater frequency in primiparae than in multiparae—from 70 to 80 per cent of the cases are primiparae—as well as in twin pregnancies, its very frequent occurrence in cases of narrow pelvis, the albuminuria which is particularly associated with the disease, the onset at the beginning of the rhythmic contractions, all these incidents are familiar to every one of us. One observer has noted that brunettes are less susceptible to the disease than are blondes, and

that, in the case of the brunettes, the attacks, when they do occur, are less severe than in the case of the blondes. Slemmons is authority for the statement that "one attack confers a relative immunity for the future."

The uniformly constant feature of the infection is the presence of the hepatic lesion, which Williams considers absolutely characteristic. Pilliet (1886-1888) in every single case of his series found hemorrhagic hepatitis, lesions of the liver which showed irregularly-shaped reddish or whitish areas scattered through the entire organ, areas of necrosis involving the periphery of the individual lobules and of the portal spaces. This is often confused at first with nephritis as the fundamental lesion of eclampsia. The renal lesions, however, are not primary but secondary causes, if they are a cause at all, which is doubtful to say the least.

The first indication of an impending attack is a twitching of the mouth or a rolling of the eyes from side to side. The fixed expression of the eye which usually preceded this sign is apt to pass unobserved. The pupils become dilated and presently, with the convulsive movements of the mouth, the whole face becomes distorted. Soon the arms, then the body, and finally the legs are affected. At times the patient becomes rigid, with stertorous breathing, congested and flushed face, foams at the mouth and often bites her tongue. One violent case is recalled wherein the patient seized a pillow between her teeth, foamed at the mouth, tore the collar and cravat from off one of the medical attendants and almost wrecked the beard of the other.

Epigastric pain, when it occurs, is a very grave and most significant symptom. One case is recorded (Berkely and Bonney, 1915) in which this was the only symptom. The pain lasted for two days and was diagnosed as dyspeptic. It was followed by a single convulsion and the death of the patient in a few hours in coma.

It is generally recognized that, in the vast majority of cases, there have been for a longer or shorter time premonitory symptoms

\*Read before the Ninth District Medical Society at Gainesville, September 17, 1924.

pointing directly to the toxemia of eclampsia, but as such they are very often overlooked, and considered merely as the usual accompaniments of any normal pregnancy. But in looking backward over the events, a certain sequence will be recognized and identified after the occurrence of the convulsive fact: The toxemia which could have been an autoxidation, the minor symptom of a kidney of pregnancy, the secondary toxemia, due to autolysis of the cells of liver and kidney both, which permeates the maternal circulation and is followed by the sudden eclamptic convulsion or coma.

The time of onset, as a rule, is not earlier than the second half of the pregnancy; it is more likely to be within the two last months, becoming more frequent the nearer term is approached. In most hospitals it is reported as occurring in about one per cent of the maternity cases. Classifying the cases as antepartum, intrapartum and postpartum, it may be said that 20 per cent are antepartum, 60 per cent are intrapartum, and 20 per cent are postpartum.

The convulsive attacks rarely last longer than two or three minutes even when they are at their worst, and are followed by stupor or coma which may last any length of time, death sometimes occurring without any awakening. Sometimes there is but a single convulsion; more often the first is but the beginning of a series which may number from four to seven or eight in mild cases, to fifteen to twenty in severe cases. They may occur at such short intervals as to seem almost continuous. During the attack the patient is wholly unconscious and has no remembrance whatever either of the seizure or of any of the accompanying details of it, afterwards. Consciousness may return, however, after each convulsion.

Gatch and Little (Indiana) report the case of a patient, thirty years old, who, about the middle of the ninth month of her second pregnancy, had five convulsions within seven hours, each more severe than all previous ones, with intervals growing shorter. Caesarean section produced a living child, although respiration was initiated

only after considerable difficulty. After Caesarean section there were no convulsions immediately and the patient rallied sufficiently to inquire after the baby. Beginning two hours after delivery, however, and continuing for thirty hours, she had 39 convulsions in rapid succession, each lasting from one to three minutes, with intervals of from five to seven minutes of coma. During the attacks the rectal temperature was 107.3° F., which was reduced by ice packs and ice enemata. After the convulsions ceased, there was profound coma for forty-eight hours, followed by gradual recovery. The patient was discharged forty days after admission, the child vigorous and healthy. The mother never recovered completely her mental health.

Zweifel has aptly designated eclampsia the "disease of theories." From very early times it was regarded as a disorder of the nervous system, peculiar to pregnancy. The so-called bacterial theory of the origin of the infection has not yet received any convincing proof. The theory that water is the essential toxin, manifested by the anemia and edema, and inducing the convulsion by the edematous swelling of the brain, was exploded by Zondek, with irrefutable evidence. The theory that eclampsia and uremia were identical infections was untenable and not always demonstrated at autopsy. The mechanical theory that the condition was due to compression of the renal veins by the gravid uterus found few supporters. That of thyroid insufficiency has not been proved. The cause is still undiscovered and all that is positively known is that the disease is accompanied by characteristic lesions in the liver and striking changes in metabolism, with objective signs of albuminuria, convulsions and coma.

The observations of Dienst and of McQuarrie have conclusively proved that there is some connection between the toxemia and the blood incompatibilities of mother and child, but they have not yet demonstrated precisely what the connection is. Obata (1923) presents evidence to the effect that insufficiency of the liver is the cause of loss

of power of the serum to neutralize the placenta toxin, and holds that this loss of power seems to be the causal factor. He invariably found this toxin-annulling action of the serum materially reduced in eclampsia, gradually returning in from three to five days after the last convulsion. Experiments on animals showed that only the liver seemed to have any influence on this toxin-annulling power. Levy-Solal and A. Tzanck (France) found that two toxic elements can be isolated from the serum of eclamptic patients. One induces a slow, torpid kind of intoxication, the other a sudden, rapidly fatal syndrome, with convulsions and other features suggesting an anaphylactic shock. This conception was confirmed by their successful prevention of experimental convulsions by injecting animals beforehand with a minute dose of the same eclampsia serum. This realized a specific desensitization. Parramore (London) maintains that the toxemia which ends in eclampsia is simply an aberration of normal metabolism, and that eclampsia is simply a uremia distinguishable from other acute uremias only in the method of its production. His conception is that the maternal visceral lesions explain the toxemia, that they are not merely terminal events in the disease; the disease may end in coma, but the coma does not produce the visceral lesions.

The temperature usually remains normal during the convulsion, but occasionally rises to a considerable height from the onset, reaching 104 to 105 degrees. Williams reports one case of a temperature of 109.5° just before the end. This complication is of very serious prognostic import. The cause of it is not known and opinions differ widely. The arterial pressure is markedly increased during the attack, the pulse full and bounding. In severe cases it becomes weaker and more rapid. There may be cerebral hemorrhages and paralysis, which offer a very bad prognosis; or edema of the lungs and pneumonia, which point to a fatal termination. Jaundice with yellow atrophy is nearly always fatal; and again, death

may come from asphyxia or exhaustion. The mortality runs from 20 to 30 per cent for the mother in eclampsia cases, and from 30 to 50 per cent for the children.

With regard to the morbid changes in the system during the period of the eclampsia there is great lack of uniformity. The changes in the liver, as has been said, are the most important and the most constant. Those of the kidney are degenerative. The most striking features are the almost universal tendency to capillary thrombosis and the occurrence of associated areas of necrosis and hemorrhage. There is general edema of the brain, with hemorrhages and the tendency to capillary thrombosis. This applies to changes in the lungs as well, with the added condition of necrotic areas. The same is generally true of the heart, together with degeneration of the myocardium. All of these changes are manifested by symptoms of dizziness, headache, vomiting, epigastric pain, disturbances of vision, scanty secretion of urine with much albumin and little urea. The most important point about the urine to be noted is the quantity. When it is suppressed or nearly so, it is a very bad outlook for the patient.

There are almost as many methods of treatment of eclampsia in vogue as there are theories of its origin. Each of them has some advocates; some of them have many. Perhaps the wisest counsel is that which says: Decide either to empty the uterus promptly, or to let it alone—and then do the thing decided. The prognosis is bad in any case both for the mother and for the child; it is worse postpartum than antepartum, and worst for multiparae. No time should be lost in indecision.

If the treatment is to be medical, the first care is for elimination; then washing out the stomach and leaving in it a strong purgative. Repeated high colonic irrigations should be given until the water returns clear. Absolute starvation is in order. Drugs are of secondary consideration.

The prophylactic treatment instituted by Stroganoff—first described in 1897—is perhaps the most widely known method of this



type. The fundamental idea is that the fits play the pre-eminent part, that the number of the fits must be reduced, and that repetition of them must somehow be prevented, as each succeeding fit brings the patient nearer to death; moreover, the greater the number of the convulsions, the greater the mortality.

Stroganoff's method is: At the beginning of the treatment a hypodermic injection of 0.015 gm. morphin hydrochlorid under chloroform. In one hours time 2.0 gm. chloral hydrate in addition to from 200 to 250 c. c. of saline solution per rectum, and when conscious, by mouth with from 100 to 110 c. c. of milk. In three hours time from the beginning of treatment, hypodermic injection of 0.015 gm. of morphine, usually under chloroform. Seven hours after the beginning of treatment, 2.0 gm. chloral hydrate. Thirteen hours from the beginning of treatment, 1.5 gm. chloral hydrate without chloroform, if there have been no fits and no prodromata for twelve hours. Twenty-one hours from the beginning of the treatment, 1.5 gm. chloral hydrate without chloroform, if there have been no fits for 12 hours and no prodromata. Thus, during one day the patient receives from 5.0 to 9.0 gm. chloral hydrate and from 0.02 to 0.04 gm. of morphine subcutaneously and repeated administration of chloroform, together with 500 c. c. of milk and 500 c. c. of saline solution. In his report of 1922, Stroganoff relates his experience with this prophylactic method which he had used over a period of twenty-four years with a total of 2208 cases. He has reduced the mortality under this treatment to 9.8 per cent for the mothers and of 12.9 per cent for the children. For the period from 1915 to 1922, with larger amounts of the sedative during the first two or three hours, he has had no deaths except patients who were moribund when first seen. He advises venesection in severe cases.

"A new fact of great importance" reported by Hinselman, Heynemand (1922-1923) consists of the spastic changes which can be directly observed in the capillaries of the skin. In 9 per cent of thirty-three cases the circulation in the capillaries was found ab-

normal. The intermittent spasm of the capillaries repeatedly arrested the blood stream altogether, but even between these periods of complete stasis the blood stream in the capillaries was found to be extremely sluggish. Fifty per cent of the cases found with signs of destruction of the red cells die. Delivery is the essential means of influencing the capillary circulation. Venesection is a valuable aid. In severe cases of eclampsia the capillary circulation is frequently entirely arrested. One of the charts in a severe pre-eclampsia showed that, in one eight-minute period, the stream was arrested 63 times, the stasis forming 42 per cent of the total period. The pregnancy induces the spasm, which usually subsides slowly after delivery.

Hugel (Munich) had already discovered in 1921 that strong solutions of sugar retarded the coagulability of the blood without destruction of the blood corpuscles. Acting on this he treated several cases of eclampsia, both with and without convulsions, with intravenous injections of a 10 per cent solution of glucose and reported very favorably on its efficacy. One of his patients had most violent convulsions; one had been unconscious for 36 hours. Both recovered. Not less than 500 c. c. of the solution is to be injected and 1000 would be more successful in cases of robust women. It must be injected slowly to prevent hypertrophy of the heart. The injection should be introduced into the median vein at 36° C.

The so-called "expectant method" was inaugurated at the Rotunda in Dublin and has been very successful there, as well as in Glasgow. The maternal mortality reported in a series of 61 cases was only 8.5 per cent. Lichtenstein (Leipzig) reports on 317 cases in all stages treated by the expectant method with only 27 deaths, and maintains that all physicians who are wholly dependent on their own resources can treat eclampsia much better than by extensive operations. He declares that the mortality for both the mother and the child has been reduced one-half by this method.

Hirst (New York), Macon (University of Virginia), Davis (Philadelphia) Davidson

(Seattle), Williams (New York) and other authorities are among those who advocate the medical treatment. Free venesection, 600 to 1000 c. c. as soon as possible after the first convulsion; delivery effected by forceps, or version and retraction; morphine for sedative; croton oil or Epsom salts; enemata. Williams found lumbar puncture, renal decapsulation, veratrum viride all worthless; whereas, Boddie (North Carolina) has never seen a case of eclampsia continue after treatment with Veratrum. Rucker (Richmond, Va.) believes that most of the mortality is due to heart failure with edema of the lungs, and that digitalis is important as a safeguard. McPherson, of the New York Lying-In Hospital, in a review of 120,000 cases, one in 185 patients being eclampsia, thinks that the blood pressure is the most alarming feature, and never of slight importance. Next, the urine as an index of the degree of toxemia is of importance. All the rest are important but less so. He lays great stress on the convulsion because he believes all cases are due to brain hemorrhage from rupture of the blood vessels. In the first stage the patient is out of balance; in the second, has entirely lost her balance. The brain lesion is revealed at autopsy when the patient has died without ever having had convulsions.

Moran (Washington, D. C.) states that he used to be classed as an interventionist for the reason that he favored cutting operations in all cases of eclampsia. Recently, however, he has adopted a more conservative treatment, individualizing his treatment according to the needs of the patients,—sometimes medical, sometimes surgical, sometimes a combination of the two. His method is to give morphia hypodermically at reasonable intervals to reduce respiratory movements to 10 or 12 per minute, bleed when blood pressure is high to reduce it to 150 or thereabouts, wash out the stomach leaving in it two ounces of castor oil, irrigate the bowels with 5 per cent glucose and soda solution by the drip method. This procedure he claims is very helpful even when surgical intervention is found necessary.

The special and absolute indications for intervention are many, inertia, uterine tetanus, rigid os, pelvic contraction, coma, proidentia of the cord, etc., and when these indications appear, operative measures suited to the condition should be undertaken at once. Parke (Philadelphia) holds that abdominal section is the operation of choice; sometimes vaginal section is considered the more advisable. Owen (London) maintains that the 30 per cent mortality in cases of Caesarean section could be materially reduced if prompt action had been taken in all cases. He reports a case wherein the interval between the first convulsion and the operation was just  $3\frac{1}{2}$  hours, with a delay due to the inconvenience of the hour of call, 1.15 a. m. The convulsion had taken place fifteen minutes earlier. The patient was cyanosed, and breathing stertously. She had complained of headache. May 10th, called on patient, she was in the 34th week of pregnancy. Caesarean section was performed at 4.35 a. m. She had severe convulsions until 11:30 that night, and at no time regained consciousness. Her temperature was from  $103.6^{\circ}$  to  $104^{\circ}$  until 6 a. m. the following day. Four hours later it dropped to  $99.4^{\circ}$  and stayed there. On the 12th she was conscious and talking. Her pulse was normal, her sight perfect. There was no headache, nor was there the slightest recollection of her illness. A rapid recovery followed and she left the hospital with her baby on June 9th.

In the minds of many eclampsia and convulsions are interchangeable terms and the conditions cannot be identical. This, however, is not the case. Zacherl (Berlin) reports two cases without convulsions but with the characteristic findings in the organs. The diagnosis of eclampsia was made at autopsy. He reviewed 188 cases of eclampsia among 32,700 maternity cases at the Graz maternity clinic, of which 20.7 per cent of the eclampsia cases died. The treatment at the clinic consisted in warding away all irritating factors; general anesthesia for all interventions; venesection plus infusion of saline; prophylactic sedatives by the Stroganoff method; and hastening delivery

by gentle measures. The condition of eclampsia without the convulsions has been given the designation of "eclampsism."

In general, the autopsy findings have been the most valuable in affording information of the disease. The liver is sometimes hypertrophied or increased in size; sometimes atrophied or decreased; sometimes yellow, sometimes mottled with red; sometimes there are hemorrhagic lesions, sometimes focal necroses. There are some infarcts, some local or diffuse infiltrations, some cloudy swelling, some round cell infiltration, some polymorphonuclear infiltration. The kidney usually is enlarged; occasionally there is pyelonephritis; changes from cloudy swelling to complete destruction; sometimes glomerular changes; the ureters are frequently distended.

In the lungs are found submucous hemorrhages in the bronchi, edema, congestion, pneumonia. The heart is usually enlarged, with myocardial degeneration; occasionally pericardial exudate; subendocardial and subpericardial hemorrhages; the pleural and abdominal cavities frequently contain yellow or blood stained exudate, sometimes in very great quantity. The brain lesions are gross hemorrhage, edema, anemia or purulent exudate.

As sequellae to eclamptic attacks, many changes are apt to occur. The heart is usually more or less involved, with degenerative changes in the myocardium, which are generally regarded as due to the disease but may be due to the chloroform used in the treatment.

The fact that 3 of 27 cases where the patients were seen at the end of a year and a half after the attack and presented signs of chronic nephritis indicates that the danger of a permanent lesion of the kidneys after eclampsia should not be misunderstood nor overlooked. The case reported by Gateh and Little is an instance of the mental effects after two and a half years, when the patient was found to have the mentality of a child of twelve or fourteen years of age. Marked mental derangement is a result in from 5 to 7 per cent of eclampsia cases of several series of cases; disturbed vision and

jaundice are other sequels, as well as symptoms.

Whatever the conclusions we arrive at with regard to this disease, and whether they concern pathology, diagnosis, medical or surgical treatment, the expectant method or Caesarean section, all must hold a secondary position to the primary present fact that "the essential feature in the morbid process in eclampsia must be assumed to be the circulation of some as yet unknown toxic substance in the blood." The problem before us is to discover this as yet unknown factor.

### PLEA FOR PERSISTENCY IN TREATMENT OF GONORRHEA\*

W. P. Jordan, M. D.,  
Columbus, Ga.

My apology, if I need one, for writing this paper is a conversation held with two prominent physicians of my City who have uncured gonorrhea and two who are patients of mine.

Gonorrhea is a contagious, catarrhal inflammation of the genital mucous membrane, mainly propagated by impure coitus, and due to specific organism of gonococcus of Neisser. The disease is marked by pain, ardor urinae, and a mucopurulent discharge, it may pass away without any serious result, or it may become chronic, involving the submucous tissue and producing urethral stricture or leaving a chronic discharge called gleet. It is frequently attended with complications, such as prostatitis, epididymitis, orchitis, and cystitis, etc. It may also produce, arthritis, and endocarditis. The prostatitis and the accompanying cystitis also tend towards the production of pyelitis and calculi; complications and sequelae in males thirty-four, females thirty-nine. Neither menstrual fluid nor leucorrheal discharge will cause gonorrhea unless they contain gonococci. Of all the troubles known to man, other than simple coryza, perhaps more people suffer with gonorrhea than any other disease. I trust that this statement is not true but am afraid that it is only too true as it comes from authority. A German

\*Read before the Fourth District Medical Society at LaGrange, Ga., August 14, 1924.



writer of repute says that in his country that there are three classes:—those who have had it, those who have it and those who will have gonorrhea. Fifty per cent of the population, white and black, male and female, have gonorrhea during their life time. The very nature of the disease of Neisser itself calls for persistent, continued and thorough treatment. It is a self limited disease, according to Keyes, after 12 to 36 months, however the gonococci is at its best when after having completed one cycle of an acute urethritis it then liberates itself from one of the glands of Littre or crypts of Morgagni, which are found throughout the urethral canal, and begins again its work of destruction. Each time allows it to get a better foothold on the submucous tissue and the various glands which complicate the course of the disease. The seminal vesicles and the prostate are both ever ready to engage and hold all of the gonococci that their capacity will entertain. May I digress here to call your attention to the fact that your patient does not have the very slightest idea of the necessity of continued treatment, nor does he realize the value of proper treatment.

In treating gonorrhea we are taught from the very earliest that there is no specific. You have tried argyrol on one patient with astounding success and then on the next there seemed to be no result at all. You will find that the same thing is true with every other doctor and every other medicine. The chances are that the patient would have gotten well any way if you had told him to use boiled water if he gets well in a few days. No one drug will cure any case on anybody, nor will any combination or drugs cure any two cases. You will have to keep trying. Every quack and semi-quack has a cure-all and so has your drug store. Though there is a law in this State that was made by our Legislature to prohibit drug stores and layity from treating gonorrhea, they still treat large numbers of cases. But to come back to the drug used in treatment, you cannot rubber stamp your patient, intelligent service will have to be rendered each individual just as any other medical

or surgical procedure would be carried out. I will not take up your time with an outline of treatment for that is not what this paper is written for, however, my observation is that the silver and mercury salts with the addition of potash and perhaps one or two newer injections constitute the bulk of the treatment. The use of mercurochrome, 220 intravenously in 1 per cent solution, 10-20 c. c. in sterile water, is to my mind one of the most wonderful and remarkable adjuncts to modern treatment. There is much to be learned concerning the use of this drug but it certainly alleviates the symptoms and shortens the course of the disease. On 12 patients to date not a one has failed to state that he felt more comfortable. In chronic cases the symptoms fade away. Dr. J. A. Thrash has had the same experience and we are both keeping careful records of the treatment hoping that others may profit by our experience. One of the main reasons that this persistency of treatment is desired is that a drug that will immediately kill the bacteria will also destroy the mucous membrane, thereby placing your patient in as bad or worse condition than he was before. Mild drugs over a continued period will bring results. At times there are drugs that will irritate your patient for a few minutes, you will have to be firm if you think that this is the drug to be used. You must use your intelligence and caution but always try to find the drug that will render satisfactory service to this individual patient. Vaccines render a part in the treatment of complications and test for cure as well as non-specific therapy. Remember, please, that proper treatment constitutes more than injections to be used at home.

The average physician falls down woefully when it comes time to test the patient out. He may spend hours in treatment but care must be used for the patients benefit before you can dismiss him as cured. This is not always due to ignorance. In discussing this matter with one of the oldest physicians in our city he made the following statement: "A week in bed with a large quantity of water to drink will cure any case of gonorrhea." He was asked what he

meant by a cure. Answer, "cessation of discharge." He also stated that he had personally had gonorrhea at the age of 14, he felt he was well when he was 20, after six years of treatment. Thirteen years ago he contracted it again and now he felt that each week he was going to have an acute case. Lack of interest due to financial consideration also plays a large part in this indifference. The only reason that this class of patients do not pay better is because you have rendered them service in the past commensurate with the fee charged and that being next to nothing. It is all your fault, which will take a little time to remedy. A thing worth doing at all is worth doing well. Suppose that you had an acute case of gonorrhea, many of you have had and many of you are suffering today from the effects of a non-cure, would you want to place yourself in the hands of a man who was willing to give a prescription for injection occasionally, ask you a few questions once a week, when the discharge has ceased for a few days, tell you to go ahead and try it out? I'll say you would not. Neither would you like to have Dr. Hugh Young himself treat you until you were free of the discomfort of a complicated case and then dismiss you without proper examination. To say the least you would want an examination of prostatic and seminal vesicle fluid, and an examination of urethra by means of urethroscope, and you would want this repeated. A severe reaction to gonorrheal vaccine indicates probably the presence of infection, 80 per cent of all individuals infected with gonorrhea, old cases, will show a positive complement fixation. I will admit that the average patient does not desire to return after he considers himself well. It is your duty as a citizen in a Christian land, as a follower of Aesculapius and the upholder of the winged staff of Mercury, to use your every influence to convince your patient of the need for a thorough examination and to point out to him what may happen if he is not well. Perhaps I should have mentioned more in the beginning that I think a doctor's first duty to a patient is to educate him, his second duty is to continue his education and

his last duty is to repeat the first two. If you will not commit yourself about the length of time that it takes to cure a case of this type you will save yourself some trouble. I have never yet told anybody how long it would take but that I regretted it before I got through. Having pointed out to them the dangers and pitfalls of the disease you can proceed with a clear conscience. Take all the time needed, if you haven't the time send him to someone else who has. Even most doctors no longer consider gonorrhea as a simple coryza of the urethra, for it and the spirocheta pallida are soul absorbing, mind devastating, and economic wasters of the highest degree. Gonorrhea alone causes untold suffering and misery of the mind and body. The cost in dollars is so enormous that it is almost beyond comprehension and loss in time and years of life can never be determined. Due to the slipshod treatment of some busy country practitioner and the city surgeon in female gonorrhea as well as the indefiniteness in males the disease is on the increase. There are physicians practicing medicine today who think and tell the patient that they will be all right in a few days. If you did your duty a large part could be counteracted. The surgeon or gynecologist will remove tubes, etc., from the women and tell her that she will never have any more trouble. That is in itself a falsehood which causes untold misery for years. The original infection can be found in the genitals this she transmits to others according to her station in life. It or a secondary infection progresses upwards to her bladder and kidneys.

My reason for writing this paper was that I might bring to you something that would cause you to realize what the patient goes through with. This is really what happens in most cases: He comes to you in three to nine days after intercourse, sometimes later of course, with an acute specific gonorrheal urethritis, you tell him that the prognosis is good, unless he has some of the numerous complications, you either give him some blue pills and an injection to use at home or you go just a step farther and ir-

rigate him for a while, in a few weeks he is well. Then he seeks another doctor because of his gleet, to his mind you are a pretty good doctor for pneumonia and he will have you for his wife but do not seem to be able to do much for the gonorrhea. Doctor number two is a surgical doctor and makes an excellent effort to overcome the gleet which he does except an occasional drop, this he tells him will disappear after a while. In a few months he goes to another doctor and says that number two is all right to cut out his appendix but not much on the gleet; he is having an occasional pain in the rectum after defecation, a burning sensation in the urethra after intercourse and urination, and an itchy feeling in the bulbous urethra. You with some psychology, a couple of real massages of prostate render him temporarily better. He then passes you up for lack of interest and so down the line until he has exhausted his possibilities. Examination then shows as follows: Slight discharge, positive for gonococci, urine loaded with pus, prostate and seminal vesicles enlarged and painful, patient comes to you with pain in the back. One or more strictures of varying caliber, urethra tender, reddened, coliculus swollen and bleeding easily. He is disgusted, has added to his misery by having infected his wife after being told by one of the doctors that he could not infect her, a trouble more dangerous and damaging has been started. He may have obtained re-infections as well as having given them during this two years. His wife not realizing the danger that she is in refuses to be treated other than taking advice as to hygienic measures. When the surgeon is compelled to operate she will then wish that she had accepted the first advice given her. As this man grows older he may develop a prostate of the old man with frequent and painful urinations, urine full of pus, kidneys that fail to function properly, subsequent uremia and death.

The above story is a true one and tells only the half. It is copied from a history in my files and the man is under treatment at the present time. To date his wife re-

fuses to be treated. I might mention that this is by no means an exception.

I am justified in taking up your time if I have convinced you that gonorrhea deserves as much time per treatment as any other major disease. The discharge is not the cause of the worry. It is the complications and sequelae. Obtain first class information of the subject, impart knowledge to your patient, and insist on his co-operation. Have and use the proper instruments with intelligence.

### THE TREATMENT OF PNEUMONIA\*

Stewart R. Roberts, M. D.,

Atlanta, Ga.

Pneumonia is a short, frank, intense disease, whose beginning is often sudden and stormy, and whose departure dramatic and almost tragic. On the contrary, it may insinuate itself in a stealthy and easy way, and linger slowly to a tedious conclusion. At any event, every case of pneumonia presents four pathological conditions which inevitably obtain in varying degrees,—(a) an inflammation of more or less lung tissue; (b) a consolidation of more or less lung mass; (c) a systemic toxemia, dependent upon the lung infection and a bacteremia with a disturbance of the centers of respiration and circulation; and (d) a strain upon the myocardium of greater or less degree. The varying physical signs in the lungs are dependent upon the first two conditions. The chill and fever, the rapid pulse and breathing, the cyanosis, the distension, and the delirium and restlessness are dependent generally upon the last two conditions.

The disease is the fourth great cause of death in the world, being outranked only by diseases of the circulation, tuberculosis and diseases of the kidney in the order named. Its treatment has varied with every period in the development of medicine. The history of the treatment of pneumonia is a rare chapter because in a narrow sense it is a history of therapeutics. Even today, different medical centers differ in many details of treatment, but in the essentials

\*Read before the Augusta (1924) meeting of the Medical Association of Ga.



scientific medicine is in general agreement. Let it be remembered, above all things, that we are dealing with a severe disease that will run its course without regard to drugs. Let it be remembered that pneumonia is not a disease that is cured by drugs but involves a far wider therapeutics. There are three classes of cases,—(a) a certain number will die despite all treatment; (b) a certain number will recover with no treatment apart from rest in bed; and (c) a certain number will recover apparently as the result of careful nursing and skilled and experienced treatment.

Prognosis in pneumonia is uncertain both as to outcome and to complications. It is probably true that the temperature, the leucocytosis, the amount of lung tissue involved, the treatment or the nursing afford no real evidence as to the prognosis. Prognosis apparently must be based only upon one finding, viz., a pneumococic bacteremia. Pneumonia patients whose blood remains bacteria free throughout the disease usually recover, whereas patients with positive blood cultures usually die. In Bloomfield's series practically every death was associated with numerous pneumococci in the blood, and "such overwhelming terminal bacteremia might be preceded by very slight blood invasions at a time when clinically the patient still seemed in excellent condition." With blood sterile to pneumococci the prognosis is good. With pneumococci in the blood, it would seem to show that the defenses are crumbling, and that the patient will die. Bacteremia is a true basis for prognosis. There seems to be no known treatment of service in a case which develops a bacteremia.

In the days of Benjamin Rush and Thomas Watson, bleeding, blisters, calomel and antimony were the weapons, and for the last 75 years quinine in one area, veratrum in another, aconite in another, creosote in another and digitalis in another have had their faithful adherents. This is the age of bacteriology and sera, and it is natural that in the centers these should have their adherents. However, it is probably true, as Cabot has said, that the mortality in pneumonia,

decade by decade for a hundred years, remains practically the same.

(a) Rest in bed is essential. The patient should be fed, use the bedpan, exhaustion by physical examination should be avoided, and visitors forbidden. The patient should be quiet in body, mind and tongue. Change of position, particularly in broncho-pneumonia, is a good rule. In the aged, change of position is wise, because the hypostatic element enters largely, and very fast if the heart weakens.

(b) In lobar pneumonia cold, fresh air is essential. Draughts should be avoided, and the porch is better than the room. The patient should be well protected by underclothing and bed covers to avoid chilling. He should not be exposed to cold air for examination or bathing. In broncho-pneumonia, on the contrary, at any age, the air should be warm and fresh but not cold, and such patients should not be exposed on porches. This applies particularly to broncho-pneumonia in infants and the aged, after measles, influenza, and other infectious diseases.

(c) The food should be liquid and soft. It is probable that a soft carbo-hydrate diet tends to less excessive abdominal distention than a heavy protein diet. Eggs, however, may be given. The point is to give the patient enough food to give him strength for the battle of his life, and to let the fever burn food rather than flesh. A pneumonia patient needs nourishment.

(d) Water is essential. It should be given freely and regularly in the form of water, lemonade, orangeade and milk. Sugar can be added freely to all three. Sodium or potassium citrate given a dram or two a day in four doses of 30 grains each is well. An excess of water is necessary.

(e) The bowels should be opened in the beginning by a gentle laxative, and not by a drastic purge. The patient is not to be weakened by purgation. A daily enema, if there is no movement by night, is a good rule. Distension is to be treated by turpentine stupes, one to four drops of turpentine to an enema, a rectal tube, pituitrin, strychnine

nine or eserin. A distended stomach calls for the quick passage of a stomach tube.

(f) For pain small doses of morphia are advisable. Codein may be given to children and the aged. A hot flaxseed poultice is good. Better still is the application of one part of olive oil to 7 of turpentine directly to the skin, cover with soft undershirt and then with oiled silk. This often relieves the pain, and at the same time affords a clean counter irritation for those who believe in blisters. A hot poultice soon becomes a cold poultice and a thoracic wallow in the mush of a cold poultice is a bad practice. A pneumonia patient must not only not suffer, but he must be made and kept comfortable. Constant pain means early exhaustion. It follows that sleep is also essential. A hypodermic of morphine at 8 P. M., and the resulting night's rest may turn the tide to comfort and recovery. An insomnia in pneumonia is dangerous. Often an eighth of morphine may be all that is necessary.

(g) There are two indications for bleeding, (a) in full blooded, healthy and plethoric patients with a terrific onset and high fever, bleeding is to be done in amount from 5 to 20 ounces; (b) later in the disease, with dyspnea, tachypnea, tachycardia, cyanosis and right heart strain, bleeding though in small amounts is a good practice.

(h) The flow of urine must be continued. In addition to fluids by mouth, solutions may be given by hypodermoclysis or intravenously. If increasing toxemia develops, 300 to 500 cc of a three to five per cent soda bicarbonate solution may be followed in 4 to 6 hours by the same amount of a 3 to 5 per cent glucose solution.

(i) For failing respiration, oxygen given through the nose and mouth early and continued persistently 10 to 15 minutes per hour is well. Expectorants are not indicated. One cannot cough up particles of a consolidated lung. After the crisis the exudate disappears more by absorption and through lymphatics than by expectoration. For edema, atrophin, and morphine should be given promptly hypodermically. For excessive cough, codein, heroin and morphine

are the choice. For restlessness and delirium the patient should be watched. An ice bag to the head constantly with frequent tepid or cold sponges are of assistance. Sleeping is better than delirium and morphia is necessary.

(j) Probably the most important indication is to support the circulation, and maintain it to as near a normal degree as possible. Strychnine in 30th to 10th of a grain doses at intervals is advisable. A better plan is to give 30 drops of a potent tincture of digitalis twice daily for at least two days, or one grain of the digitalis leaf three times daily for the first two days. The digitalis can be resumed later in the disease if cardiac symptoms appear. For acute failure, coffee by mouth or rectum, caffeine-sodium-benzoate in 5 to 7½ grains hypodermically, adrenalin in ½ to 15 drops doses hypodermically or camphor in oil in 5 grain doses is advisable. For the collapse of the crisis morphine and atropine or adrenalin hypodermically are best.

(k) The mass of evidence seems to show that the Type I serum is of value in a Type I infection. Types II, III, IV sera do not seem so valuable. As a whole it may be said however that the serum treatment of pneumonia is thus far disappointing. The difficulty in typing precludes, except in the populated centers, the general use of Type I serum. The intravenous use of serum from pneumonia convalescent cases in doses of 5 to 30 cc every six hours for 2 to 4 doses offers some promise. The serum may be taken at any time after the crisis is past up to two weeks. Stengel is using this method in Philadelphia. It is used often in influenzal pneumonia and in the ordinary lobar pneumonia. The serum is not used unless the Wassermann is negative. It is better to use 10 cc doses in the beginning.

The complications of pneumonia are to be treated on their merits. As a rule, after the crisis the patient can be allowed to sit up in from one to two weeks, depending upon the condition of the circulation.

A few simple rules are of service:—

1. In the treatment of pneumonia, maintain an elastic routine. Keep therapeutical-

ly open-minded. Treat the symptoms as they arise.

2. Avoid cardiac depressants.
3. Maintain the circulation.
4. Use liquids freely to decrease the toxemia. A large urine output is necessary.
5. Keep the patient comfortable. Relieve his pain. A comfortable sleep every night is desirable.
6. The patient is to be given a food intake sufficient to maintain strength.
7. The fever is to be reduced by water internally and externally, by cold air, and by an ice bag to the head.
8. The pain may be relieved by morphine, by strapping the affected side or by counter-irritation.
9. The patient should have a good bath daily.
10. The patient's mouth, nose, body and bed should be clean, and the air fresh and pure.
11. Avoid pinning one's faith to a single medicine. There is no specific for pneumonia.
12. Careful nursing is probably more important than drugs.
13. In general the fever the drugs and the wisest the clinical judgment the safer the patient.

#### Discussion on Paper of Dr. Stewart R. Roberts

DR. E. C. THRASH, Atlanta: This is one paper that I wanted to hear and I am glad to have had the opportunity. I waited to discuss it and wish to congratulate Dr. Roberts. I will mention only a few outstanding things that have come under my observation.

One may have a pneumococcal infection and yet not a pneumonia—an infection of the blood without a pronounced pneumonitis. This is one instance where the serum will help. I have cultured blood and cured patients with serum before they developed pneumonia in several instances.

The principal features in the treatment of pneumonia are making the patient comfortable, taking care of the right side of the heart, and relieving the intoxication. I will simply mention morphine as taking care of the comfort. We might use opium instead of morphine. In taking care of the right side of the heart we must think of the very

best methods, because the right side is thin, it is supposed to carry on very light work, simply pumping the blood through a loose lung structure that is adjacent and surrounding the lung, and for this Nature has made the right ventricle thin walled and weak, not only because it has little work to do but because it is in this way made a safety valve. It dilates and opens up the tricuspid valve causing a back flow of the blood. We can do by bleeding what Nature does by dilating the right side of the heart, and I think this is important in pneumonia in the pronounced cases. In this way the strain can be relieved and the heart safe guarded.

Other valuable remedies which we have for this purpose are digitalis and pituitrin. Pituitrin is especially valuable in the gaseous distended cases and it also seems to have a sustaining effect upon the heart. Digitalis is one of the best drugs in pneumonia, but one of the most dangerous. It should never be given for longer than thirty-six hours. If one starts with a full dose and continues for two or three days patients rarely get well. Full doses of digitalis should either produce results or be discontinued. Pituitrin also must be used with precautions, one-half ampule every three to eight hours, according to the patient.

Recently some work has been done in the preparation of antibodies, which are made just as sera are made except that after the serum is produced the pneumococcal germs are added to the serum and as soon as they begin to soften they are quickly washed and the antibodies extracted from them with normal saline I have used this in a few cases and the patients have done well. I use the sera in suitable cases and do not take time to type. The distinct lobar types and many of the broncho-pneumonias will respond to serum and the earlier it is given the better are the results. If it is given late it will be of no value unless it is used in small doses, as Dr. Roberts suggests, and then you get just the action of the foreign protein and not of the antibodies introduced.

DR. R. L. MILLER, Waynesboro: I was very glad to hear Dr. Roberts' paper and also Dr. Thrash's discussion and their caution against the indiscriminate use of digitalis. More patients with pneumonia have been killed by digitalis than have been cured.

Dr. Thrash mentioned the pneumococcus antigens. I have had opportunity to try them out in only three cases, one in an alcoholic about fifty-seven years old that I had absolutely no hopes of, but fortunately



I used it on this case in the very beginning. It was the first I ever had used and I got wonderful results. The results were so encouraging that afterward I tried it out in two other cases of lobar pneumonia, also with happy results. The theory is at least on a sound basis. If we can supply through diphtheria antitoxin the anti-bodies necessary to fight the Loeffler bacillus, it seems feasible to believe that we can do this with the pneumococcus. I am hopeful that we have a valuable adjunct in the treatment of pneumonia in these pneumococcus antigens.

DR. J. W. PALMER, Ailey: I rise to thank the essayist for his able paper. I think it repays me for the three and a half days I have lost at this meeting, aside from the other benefits I have received. Dr. Roberts has completely covered the ground. I was particularly impressed with the idea of semi-digitalizing the patient in time to be ready to digitalize him fully when necessary. I find that many wait too long to stimulate the heart. It is a question to know when to stimulate the heart in pneumonia, and it is very important. We may stimulate too soon or wait until too late. One of my ways of knowing just when to stimulate is due to the blood pressure instrument. I always take the blood pressure just before the crisis, or when I am expecting it and am expecting them to need stimulants.

I would like to ask Dr. Roberts to tell us in closing whether he does anything for the high temperature. Is it best to let Nature take care of it or does he use means of reducing it?

Dr. Roberts spoke of the convalescent patient in pneumonia being overcharged with bacteria in the blood, and said that by bleeding them and reintroducing the serum in the pneumonia patient you would introduce antibodies without depending upon Nature to remedy this. I would like to know if he has to get this serum direct from a convalescent patient, or if there is a way of obtaining the sera without depending upon a convalescent patient. In many instances one might not be able to get serum from a patient who is convalescent.

DR. STEWART R. ROBERTS, Atlanta, (closing). I think the point Dr. Thrash made about the relation between distension and bacteria is one we should all remember. He said that patients with distension in pneumonia usually die. I do not know, but I am disposed to feel that there is some relation between the distension and the presence of pneumococci in the blood. I am sure that it is a dangerous state and probably gives us some gross idea of the severity.

In regard to the digitalis, there are two schools. First, those who begin with digitalis and give it all the way through as a routine. The second would wait until something happens, or begins to happen, tachycardia, falling blood pressure, symptoms of right heart failure and so on, and then give it. The argument against the latter is that digitalis in massive doses does not have an effect for seventy-two hours. The third school does not give it as a routine, neither does it wait. In the beginning they give digitalis gently for one or two days, ten drops morning and night, and somewhat digitalize the heart and then, if anything develops, they begin to give digitalis with greater courage and in larger doses. The third school is probably the wiser, but in any event do not give too much.

In regard to the sera: The work of the Rockefeller Institute in regard to typing has been disappointing. Typing is difficult, some of us cannot do it, but Type 1 serum is all right. Stengel has shown that with this serum the antibodies do not last longer than two weeks. Others have had different results. There are some in the profession who think antigens are of value. I think there is a feeling that antigens should be given without waiting for the crisis or other deplorable conditions. They should be given early in small doses in order to avoid reaction.

Dr. Palmer's question about temperature is a mooted one. In the old days, in the fifties they gave veretrum and aconite. Later these were dropped and the acetanilid and antipyrin and the coal tars were given in the nineties. Since Osler's day we have had the feeling that the temperature was to be left to Nature but that we can use with great advantage water, internally, externally and eternally, and an ice bag to the head. I have never believed that an ice bag to the chest in pneumonia was advisable, especially in lobar pneumonia, but there is a great difference of opinion. If I had pneumonia I am sure I would be glad to have an ice bag on my head to reduce my temperature but I would not want it on my chest.

I believe we are on the eve of a great advance in regard to the serum treatment of pneumonia. I believe that the Rockefeller serum on the whole has been disappointing. What we want is something that any man, anywhere, any time, day or night, can use for his patient with pneumonia, without having to wait for a laboratory report on this or that thing, or some other delay. I thank you.

**THE JOURNAL**OF THE  
MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Profession of Georgia.

65 Forrest Ave., Atlanta, Ga.

MARCH, 1925

ALLEN H. BUNCE, M. D., Editor  
 M. C. PRUITT, M. D., Business Manager  
 Publication Committee  
 CHAS. USHER, M. D.  
 S. J. LEWIS, M. D.  
 T. C. THOMPSON, M. D.

Articles are accepted for publication on condition that they are contributed solely to this Journal.

Manuscripts should be typewritten, double-spaced, and the original (not the carbon copy) submitted. Used manuscript is not returned unless requested.

Communications and items of general interest to the profession are invited from all parts of the State. We especially invite county society secretaries to send us information of happenings in the county that would be of interest to the members throughout the State.

## Editorial Department

### THE FIGHT AGAINST CANCER

We are in receipt of the annual report for 1924 of the Cancer Commission of the Medical Society of the State of Pennsylvania and extend to the Society our congratulations for the good work done by the Commission. It is encouraging to find that, as a result of the efforts of Dr. Wainwright and his associates, both patients and physicians are beginning to realize the value of prompt action when suspicious lesions are discovered. It seems that Dr. Wainwright has directed his efforts largely towards the education of the medical men, leaving the task of educating the public to the American Society for the Control of Cancer. Such an arrangement is a wise one and seems to have brought good results in Pennsylvania, for the tabulated reports show that people are seeking medical advice much earlier and the doctors are undoubtedly acting more promptly and, we hope, with better final results, thus proving conclusively that "Cancer Education Does Pay."

The Medical Association of Georgia created a Cancer Commission in 1917. From the first the Commission has worked with the

National Society, directing its efforts to both the profession and the public. No survey of results has been made, but from reports coming from every part of the State, we feel sure that much good has been accomplished.

Two years ago the State and National organizations were combined so far as the personnel of the Commission and District Chairmen were concerned. We now have a splendid corps of more than two hundred district, county and local chairman at work. Last year the National Society sent literature direct to these men and it was widely distributed.

We have been under the impression that the national Society wishes to keep its educational work in hands of medical men, and we thoroughly agree with this plan for the reason every time a medical man addresses a public meeting he must devote some time to the study of his subject. We, also, feel that such organizations as the Parent-Teacher Association and Women's Clubs should be frequently reminded of the necessity of cancer education, so that the doctor in the community will be called upon to deliver these lectures.

The people of Georgia are greatly indebted to the State Medical Association as well as the American Society for the Control of Cancer, because the money to finance our activities has been appropriated by the former organization. It would have been impossible to distribute the vast amount of literature sent us by the National Society had we not had the financial aid of the home Association.

Again referring to the Pennsylvania report, we note that 10 per cent of the doctors in Pennsylvania are responsible for the patients' delay in seeking proper treatment, and I agree with the statement, "That these men have a great deal to answer for, for as Dr. Pancoast says, 'they are the ones who never go to medical meetings and never read the Journals.'"

When we note the great improvement in health conditions and the fact that the average human life is now 58 years while it was

only 35 at the beginning of the 19th century we are forced to say that it is "Great to be a (Georgia) doctor," and hope in time that some one of our number may discover the cause and cure of eaneer.

J. L. CAMPBELL.

### THE COMING MEETING OF THE MEDICAL ASSOCIATION OF GEORGIA

The Committee of Arrangements of the Fulton County Medical Society has held several meetings and is planning to make the convention of the Medical Association of Georgia, which takes place in the second week of May, a big success.

The meetings will be held at the Biltmore Hotel where the accommodations are excellent and prices reasonable. It has been decided to have two banquets. The Women's Auxiliary of the Fulton County Medical Society will entertain the visiting doctors' wives in the grill room of the hotel, and the regular banquet for the doctors will take place in the dining room. After the conclusion of the official functions a dance will follow.

No efforts will be spared to make the stay of the visiting members with their ladies a most profitable and enjoyable one.

### LOUISIANA JOINS STATES DEMANDING CERTIFICATES OF HEALTH BEFORE MARRIAGE

Louisiana has joined the ranks of States requiring a physical examination and a clean bill of health as a pre-requisite to the issuance of a marriage license. At the last session of the legislature, the law-makers passed the Ducros Bill making it compulsory for any male applying for a marriage license to obtain from a licensed physician a certificate showing that he is free from venereal or other constitutional disease.

According to the Division of Venereal Diseases of the United States Public Health Service, such legislation has steadily gained favor since the war inasmuch as it is a distinct measure to prevent infection of innocent wives and unborn children. The incidence of congenital syphilis and of infant blindness due to gonorrhea is responsible for the enactment of such laws to prevent venereal diseases. Several States have adopted laws similar to the Louisiana bill. One State requires the prospective groom only to state that he is free from disease. Another stipulates that a certificate of health is necessary only when the applicant has been previously infected with a venereal disease,

while the laws of a few States are identical with the Ducros Bill.

North Carolina, Oklahoma, Pennsylvania, Indiana, Michigan, Oregon, Alabama and Utah are among the States requiring a physical examination of the male and a certificate of health precedent to the securing of a license to marry.

### HEALTH WEEK IN ATLANTA

Honorable Mayor Walter A. Sims, of Atlanta, has issued a proclamation, designating the week of May 10-16 as "Health Week" in Atlanta.

This will be held during the week of the session of the Medical Association of Georgia.

It is proposed that observance of "Health Week" include short addresses in churches on May 10th, lectures before civic bodies by visiting physicians, attending the meetings of the Medical Association of Georgia, and a health parade on Friday, May 15th during the afternoon, in which the City of Atlanta, the medical and dental fraternities, the Anti-Tuberculosis Association, the Red Cross, the Nurses Association, the Y. W. C. A., the Y. M. C. A., the public and private schools, civic bodies and other groups interested in the subject of health, will participate.

The parade will consist of three distinct divisions of floats, the first representing all the health activities of the child from the time it arises in the morning until it retires at night, the second division representing the physical recreational activities of the child and adult in all its phases, the third division representing the city departments of health showing the very latest methods of keeping a city clean and preventing disease.

TOEPEL.

### RECTAL PATHOLOGY IN THE NEGRO

The series of cases analyzed by Curtis Rosser, Dallas, Texas (Journal A. M. A., Jan. 10, 1925), would indicate that rectal disease in general is equally prevalent in the two races; that cancer, pruritus, fissure and spastic sphincter are less common in the negro, and prolapsus equally common. The inflammatory conditions of the region are definitely more often seen in the negro as is fistula. Benign fibrous stricture occurs eleven times as often in the negro, being accompanied often by other manifestations of the fibroplastic diathesis. Hemorrhoids in this series occurred twice as often in the Caucasian race, there being apparently an excess of fibrous tissue in the hemorrhoid in the colored cases. Granuloma inguinale, pathologically a connective tissue lesion, occurs sufficiently often around the anus to be considered in the diagnosis of any chronic ulcerative lesion of this locality in the negro. From the data at hand, it would seem permissible to infer that the inherent tendency of the dark skinned races to form fibrous tissue in excess—the fibroplastic diathesis—is in evidence to rectal pathology of the race as elsewhere.



## District and County Societies

The Secretary of each county society shall report to the Journal of the Medical Association of Georgia full minutes of each meeting and forward to it all scientific

papers and discussions which the society shall consider worthy of publication.—Constitution and By-Laws, Chap. VII, Sec. 15.

1. Demmond, E. Carson, Savannah.
2. Wood, A. W., Albany.
3. Greer, Chas. A., Oglethorpe.
4. Blackmar, Francis B., Columbus.
5. Clay, Grady E., Atlanta.
6. Hawkins, T. I., Griffin.

7. McCord, M. M., Rome.
8. Carter, D. M., Madison.
9. Bennett, J. C., Jefferson.
10. Lee, F. Lansing, Augusta.
11. Penland, J. E., Waycross.
12. Cheek, O. H., Dublin.

### HONOR ROLL

The following is a list of 100 per cent counties for 1925. The date on which each became a 100 per cent society appears after the name of the society, together with the name of the Secretary:

1. Randolph County, Dr. G. Y. Moore, Cuthbert, December 9, 1924.
2. Dougherty County, Dr. J. A. Redfearn, Albany, December 10, 1924.
3. Pike County, Dr. M. M. Head, Zebulon, December 12, 1924.
4. Hart County, Dr. W. E. McCurry, Hartwell, January 3, 1925.
5. Warren County, Dr. A. W. Davis, Warrenton, January 14, 1925.
6. Monroe County, Dr. W. J. Smith, Juliette, January 14, 1925.

### 11TH DISTRICT MEDICAL SOCIETY

The 11th District Medical Society held its annual meeting in Valdosta, at the Valdes Hotel, January 13, 1925. It was called to order by the President, Dr. J. P. Harrell, Brunswick. A telegram from Dr. J. W. Daniel, Savannah, expressing his regrets at not being able to be present, was read. The address of welcome was given by Dr. J. M. Smith, Valdosta, with response by Dr. W. C. Hafford, Waycross. The following papers were then read:

Dr. B. H. Minchew, Waycross, "Acute Eye Inflammations in the New-born." Discussed by Drs. Smith, Greer, Hafford and Harrell.

Dr. W. D. Mixson, Waycross, "Milk and Salicylic Acid in Inflammation of the Anterior Segment of the Eye." Discussed by Drs. Minchew and Hafford.

It was then decided to proceed with the election of officers and adjourn the meeting so that the golf enthusiasts could get a

little fresh air, the remaining papers to be read after dinner. The result of the election of officers was as follows:

President—Dr. W. C. Hafford, Waycross.

Vice-President—Dr. P. C. Quarterman, Valdosta.

Secretary-Treasurer—Dr. J. E. Penland, Waycross.

Counsellor—Dr. J. P. Harrell, Brunswick.

The Lowndes County Medical Society was host at a very enjoyable dinner given at 8:30 at the Valdes Hotel, after which the regular program was resumed.

Dr. J. E. Penland, Waycross, "Chronic Gastric Ulcer." Discussed by Dr. Bird.

Dr. J. W. Simmons, Brunswick, "Fracture Dislocation of Dorsal Vertebra (With Report of Case)." Discussed by Drs. McCullough, Bird, J. M. Smith.

Dr. Kenneth McCullough, Waycross, "Syphilis as Related to Industrial Wounds." Discussed by Drs. Quarterman, Minchew, Hafford and Simmons.

Dr. H. J. Carswell, Waycross, "Fraternalism." General discussion of this paper and suggestions for the upbuilding of the 11th District.

The Midsummer meeting is to be held in Brunswick and St. Simons Island during July.

The following 23 members of the 11th District Society were present:

Ware County: Drs. W. C. Hafford, Waycross; W. D. Mixson, Waycross; J. E. Penland, Waycross; H. J. Carswell, Waycross; Kenneth McCullough, Waycross; B. H. Minchew, Waycross.

Glynn County: Drs. J. P. Harrell, Brunswick; J. W. Simmons, Brunswick; C. B. Greer, Brunswick.

Lowndes County: Drs. J. M. Smith, Valdosta; Frank Bird, Valdosta; A. G. Little, Valdosta; P. C. Quarterman, Valdosta; F. H. Thomas, Valdosta; D. W. Freeman, Valdosta; A. Griffin, Valdosta; J. F. Mixson, Valdosta; T. M. Talbot, Valdosta; G. T. Crozier, Valdosta, and Dr. Pennington.

Berrien-Lanier Counties: Dr. W. C. Rentz, Nashville.

Cook County: Drs. W. M. Shepard, Adel; H. W. Clements, Adel.

Respectfully submitted,  
J. E. PENLAND, M. D., Secretary.

### MUSCOGEE COUNTY MEDICAL SOCIETY

The January meeting of the Muscogee County Medical Society was held in the City Hospital, Columbus. Dr. Jordan, the newly elected president, presided.

The first part of the meeting was devoted to a "get together" meeting with the Public Health Nursing Association. Various perplexing difficulties of the nurses were discussed.

It was decided to start a nucleus of a medical library in connection with the Columbus Public Library. The following donations were made as a start:

Dr. Mercer Blanchard—1 year's subscription to The American Journal of Diseases of Children. Also files of American Journal of Medical Sciences.

Dr. Pennington—1 year's subscription to "The Journal of the American Medical Association."

Dr. Frank Norman—1 year's subscription to the Southern Medical Association.

Dr. Francis Blackmar—1 year's subscription of The Journal of Otolaryngology.

Dr. Bert Tillery—1 year's subscription to Surgery Gynecology and Obstetrics.

At the February meeting of the Muscogee County Medical Society we were the guests of Mr. Karl Meadows, of the Doctors' Drug Store. A supper was served in the Doctors' building. During the supper music was furnished by an orchestra. Mrs. Liggin sang Tosti's "Good Bye." Drs. S. B. Liggin, from Montezuma, and Frank Norman, from

Greenville, who have recently moved to Columbus, were introduced to the members of the Society, also two visitors from Fort Benning.

Dr. J. H. McDuffie, Sr., read a paper on "Heliotherapy."

Dr. Henry Brooks read a paper on "Tuberculosis of the Hip." These papers were followed by a brisk discussion. After a rising vote of thanks to Mr. Meadows the meeting was adjourned.

FRANCIS BURTON BLACKMAR, M. D.,  
Secretary.

### FULTON COUNTY MEDICAL SOCIETY

A very interesting meeting of the Fulton County Medical Society was held at the Academy of Medicine, Atlanta, January 22, 1925. Dr. Theo Toepel presided.

There were two Case Reports: Dr. A. M. Dimmock reported "An Interesting Case of Typhoid Fever;" Dr. W. B. Emery reported "An Unusual Urinary Calculus." Drs. Estes, Champion and Ballenger and J. L. Campbell discussed Dr. Emery's case report. Dr. E. G. Ballenger presented a Clinical Talk on a "Device for Controlling Hemorrhages after Prostatectomy." Among those to discuss Dr. Ballenger's talk were Drs. Boland, Champion, Emery and Goldsmith. The paper of the evening was read by Dr. M. Hines Roberts on "Spinal Fluid in the New Born with Special References to Intracranial Hemorrhage." This most interesting paper was discussed by Drs. Calhoun, Dowman, Bartholomew, Owensby, Emery, Hoppe and Yampolsky.

On February 5th, a regular meeting was held, Dr. Toepel presiding. There were 182 members present.

Dr. N. W. Baird gave a case report, "Parametric Abscess," which was discussed by Drs. Boland and Denton. Dr. N. W. Adkins gave a case report, "Case of Recurrent Enlarged Thymus Gland," discussed by Dr. Landham. Dr. Mell Aycock reported a case of "Appendicitis During Early Pregnancy." Dr. Wm. S. Stone of the Memorial Hospital in New York was present and spoke on "Bone Tumors."

Under Announcements, Dr. Toepel requested that members of the Society who had taken books to review would give the matter their prompt attention as the offer to give the new publications to the Library would have to be discontinued if the members failed to have ready the reviews for publication.

Respectfully submitted,  
Grady E. Clay, M. D., Secretary.

### MITCHELL COUNTY MEDICAL SOCIETY

The Mitchell County Medical Society met in Camilla, Friday, January 23, 1925. Dr. O. G. Crawford, Sale City, was elected President and Dr. D. P. Luke, Camilla, Secretary-Treasurer. The following members paid up for 1925:

Dr. O. G. Crawford, Sale City.  
Dr. A. F. Stevens, Sale City.  
Dr. J. R. Clements, Pelham.  
Dr. B. Williams, Pelham.  
Dr. J. M. Spence, Camilla.  
Dr. C. A. Stevenson, Camilla.  
Dr. D. P. Luke, Camilla (paid Secretary of Worth Co.)  
Dr. F. L. Lewis, Camilla.  
Dr. C. L. Roles, Camilla.

There are three new members being welcomed in Mitchell County. Dr. O. G. Crawford comes to us from Sasser, Dr. Luke from Ashburn and Dr. Stevenson from Winter Garden, Florida.

C. L. Roles, M. D., Secretary, (1924).

### COUNTY SOCIETIES REPORTING FOR 1925

We now have 995 paid up members for 1925 compared with 448 through January 31, 1925 and 109 through December 31, 1924.

### CAMPBELL COUNTY MEDICAL SOCIETY

The Campbell Medical Society announces the following officers for 1925:

President—Dr. T. J. Busey, Tyrone.  
Vice-President—Dr. A. B. Jones, Tyrone.  
Secretary-Treasurer—Dr. A. J. Green, Union City.  
Delegate—Dr. R. T. Camp, Fairburn.

### GWINNETT COUNTY MEDICAL SOCIETY

The Gwinnett County Medical Society announces the following officers for 1925:

President—Dr. W. J. Hutchins, Buford.  
Vice-President—Dr. N. J. Pierce, Suwanee.  
Secretary-Treasurer—Dr. N. J. Guthrie, Norcross.  
Delegate—Dr. D. C. Kelly, Lawrenceville;  
Alternate—Dr. G. S. Kelly, Lawrenceville

### DOUGLAS COUNTY MEDICAL SOCIETY

The Douglas County Medical Society announces the following officers for 1925:

President—Dr. C. V. Vansant, Douglasville.  
Vice-President—Dr. W. H. Reid, Douglasville.  
Secretary-Treasurer—Dr. D. Houseworth.

### BURKE COUNTY MEDICAL SOCIETY

The Burke County Medical Society announces the following officers for 1925:

President—Dr. W. R. Lowe, Milville.  
Vice-President—Dr. J. M. Cook, Sardis.  
Secretary-Treasurer—Dr. J. B. Lewis, Waynesboro.

Delegate—Dr. W. C. McCarver, Vidette;  
Alternate—Dr. U. H. Keley, Waynesboro.

Board of Censors—Drs. W. R. Lowe, J. M. Cook and J. B. Lewis.

### BUTTS COUNTY MEDICAL SOCIETY

The Butts County Medical Society announces the following officers for 1925:

President—Dr. A. F. White, Flovilla.  
Vice-President—Dr. O. B. Howell, Jackson.  
Secretary-Treasurer—Dr. J. Lee Byron, Jackson.

Delegate—Dr. A. F. White, Flovilla.  
Board of Censors—Dr. A. J. White, W. H. Steele and J. Lee Byron.

### MONROE COUNTY MEDICAL SOCIETY

—100%

The Monroe County Medical Society announces the following officers for 1925:

President—Dr. B. L. Smith, Forsyth.  
Vice-President—Dr. Cullen Goolsby, Forsyth.



Secretary-Treasurer—Dr. W. J. Smith, Juliette.

Delegate—Dr. G. L. Alexander, Forsyth.

Board of Directors—Drs. G. L. Alexander, Cullen Goolsby and R. C. Goolsby, Sr.

Monroe County is the 6th Society to be placed on the Honor Roll for having a 100% membership.

### JENKINS COUNTY MEDICAL SOCIETY

The Jenkins County Medical Society announces the following officers for 1925:

President—Dr. M. E. Perkins, Millen.

Vice-President—Dr. Q. A. Mulkey, Millen.

Secretary-Treasurer—Dr. C. Thompson, Millen.

Delegate—Dr. C. Thompson, Millen.

### WHITFIELD COUNTY MEDICAL SOCIETY

The Whitfield County Medical Society announces the following officers for 1925:

President—Dr. Trammel Starr, Dalton.

Vice-President—Dr. J. C. Rollins, Dalton.

Secretary-Treasurer—Dr. B. L. Kennedy, Dalton.

Delegate—Dr. J. C. Rollins, Dalton; Alternate—Dr. B. L. Kennedy, Dalton.

Board of Censors—Drs. H. L. Erwin, B. L. Kennedy and J. H. Steed.

### NEWS ITEMS

Dr. J. Lee Byron, of Jackson, having retired from active practice, has been elected as an honorary member of the Butts County Medical Society. He was graduated from the Atlanta Medical College March 4, 1887, and moved the following month to Jackson to practice, where he has been located for 28 consecutive years. He was re-elected Secretary-Treasurer of his County Society, having held this office for the past three years. Dr. Byron was responsible for the members not having to pay County dues.

Dr. R. V. Martin has been elected Medical Director and a member of the Board and Dr. Charles Usher has been appointed Chief of the Staff of the Savannah Hospital. Dr. C. B. Edwards is also a member of the Board. Dr. Martin was President of the Chatham County Medical Society during 1924 and Dr. Usher is Councillor from the First District.

We have just heard from Dr. Myron B. Allen, of Hoshilton. Dr. Allen has been in Chicago taking a course and is now at the Mayo Clinic. He intends staying there a month longer and return in time for the semi-annual meeting of the Ninth District Medical Society, of which he is President, during March. Dr. Allen represented the Jackson County Medical Society as Delegate at the Augusta meeting last year.

Dr. J. M. Poer, of West Point, was elected President of the Surgical Association of the Atlanta and West Point, Western of Alabama and the Georgia railroads at the second annual meeting held in Atlanta, February 7, 1925. He succeeded Dr. H. M. Michel, of Augusta. Dr. H. M. Fullilove, of Athens, was elected Vice-President. Members of the Executive Board include Drs. J. R. Garner, Atlanta; Geo. W. Fuller, Atlanta; J. M. Poer, West Point; J. W. Palmer, Ailey; and Willis Jones, Atlanta. Dr. Garner was host to the members present at a luncheon in the Henry Grady Hotel.

Dr. William R. Dancy, Savannah, has been named Department Surgeon of the Sons of Confederate Veterans, with headquarters in Louisiana. Dr. W. M. Dunn, Atlanta, was appointed as Dr. Dancy's assistant.

Dr. Stewart R. Roberts, of Atlanta, and President of the Southern Medical Association, was elected President of the Atlanta Alumni Club of Emory University at the "Charter Day" Banquet held January 26, 1925. "Charter Day" was in celebration of the tenth anniversary of the founding of the University.

Dr. M. L. Currie, Vidalia, has a record which is certainly hard to beat. He joined the State Association in 1890 at Brunswick, and has not failed to pay his dues a single year since that time. For 35 years he has faithfully served the Association. Dr. Currie is a member of the Toombs County Medical Society.

Dr. W. C. Pumpelly, Macon, was stricken with a sudden illness as he was preparing to get in his automobile to make a professional call and collapsed on the sidewalk. Thursday morning, January 29, 1925. He was taken to the Macon Hospital. Our latest report was very favorable, stating that he was out of danger and had returned to his home.

The friends of Dr. W. J. Smith, of Juliette, and Secretary-Treasurer of the Monroe County Medical Society, will regret to learn that he contracted

pneumonia the latter part of November and, at the time we go to press, is still confined to his home on account of complications which set in.

Dr. Cleveland W. Findley, formerly of Uvalda, is now located in Vidalia. Dr. Findley is the past President of the Montgomery County Medical Society. Upon his removal to Vidalia he was elected Secretary-Treasurer of the Toombs County Medical Society.

Dr. C. M. Caldwell was nominated as City Physician (Augusta), in charge of contagious diseases. He is a member of the Richmond County Medical Society.

Dr. D. P. Luke has removed from Ashburn to Camilla. He has transferred his membership from the Turner County Medical Society to the Mitchell County Medical Society, of which he has been elected Secretary-Treasurer.

Dr. James N. Carter, of Savannah, has had as his guest, his brother, Dr. W. W. Carter, formerly of Macon and now one of the leading laryngologists of New York. A special meeting of the Georgia Medical Society (Chatham County) was called so that the members could have the opportunity of hearing Dr. Carter give a lecture on "The Correction of Nasal Deformities."

Dr. L. G. Hardman is having a large business office built in Commerce. It is to be one of the handsomest and largest buildings that has ever been erected in Commerce. Dr. Hardman is a member of the Jackson County Medical Society.

Dr. James F. Burdshaw is being welcomed back to Georgia after having been away a year taking special courses in the study of eye, ear, throat and nose. While in New York he attended the New York Eye and Ear Infirmary, the Roosevelt Hospital and the New York Post-Graduate School and Hospital. Dr. Burdshaw has reopened his offices at No. 4 Johnson Building, Augusta.

Dr. Z. S. Cowan was elected Chief of the Staff of the Anti-Tuberculosis Association for the year 1925. Dr. C. C. Aven was the Chief during 1924, during which time the Association showed marked improvement. Both Drs. Cowan and Aven are members of the Fulton County Medical Society.

Dr. F. L. Cosby, Jr., a member of the Muscogee County Medical Society, after practicing for some time in Miami, Florida, decided that there was no place like home and has returned to Columbus. Dr. Cosby has accepted the charge of the Ortho-

pedic Service, which was just recently established in the City Hospital, Columbus. He now has offices in the Third National Bank Building.

Dr. G. R. Maner has removed from Warrenton, where he was a member of the Warren County Medical Society, to Seephyrhills, Florida. His friends that he is leaving behind are wishing him success in his new location.

Dr. W. B. Jordan, formerly of Bartow, is now located in Homestead, Florida. He is the past Secretary-Treasurer of the Jefferson County Medical Society.

A letter was received from the Frederick J. Haskin Bureau, of Washington, D. C., asking for the name of the specialist who is in charge of Dr. F. Phinzy Calhoun's practice, as one of their subscribers desired a copy of a prescription Dr. Calhoun gave to a patient about five years ago. Dr. Calhoun is still "very muchly" in charge of his own practice and has not yet had to turn it over to another specialist. He has offices at 436 Peachtree Street, Atlanta, and is a member of the Fulton County Medical Society.

Dr. H. J. Carswell, of Waycross, has been elected commander of the Ware County Post, No. 10, of the American Legion. He is succeeding Dr. B. H. Minchew, also of Waycross.

Dr. A. H. Huckaby is now practicing in Griffin, with offices over the Second National Bank. He was formerly of Milner and will transfer his membership from the Lamar to the Spalding County Medical Society.

Dr. John K. Train, of Savannah, and the newly elected President of the Georgia Medical Society (Chatham County), was the principal speaker at the meeting of the Lions' Club, which was held in Savannah, January 27, 1925.

Dr. J. Emory Clay has established offices at The Clinic Hospital, Macon. He is one of the youngest practicing physicians in Macon.

Dr. J. R. Clemmans, of El Paso, Texas, has assumed his duties as House Physician of the Macon Hospital, Macon. He is a graduate of the University of Tennessee.

Atlanta doctors, who are contemplating changes of location, must notify the Southern Bell Telephone and Telegraph Company and have contracts complete before April 1st, in order to be listed in the next directory. The directory is issued twice

a year, April 1st and October 1st. This also applies to listings with the Doctors' Exchange.

The Special Building Committee, which has charge of the building of the new Alto Sanatorium, met January 29th to go over the blue prints and plans. This committee is composed of Drs. T. F. Abercrombie, Atlanta; M. S. Brown, Fort Valley; A. C. Shamblin, Rome; W. I. Hailey, Hartwell; and Mr. Robert F. Maddox, Atlanta.

The County Health Officials of Georgia have launched a campaign to free Georgia from typhoid and malaria. Speakers at the meeting held in Atlanta, January 31st, included Drs. C. L. Ridley, Macon; L. L. Welch, Marietta; M. A. Fort, Atlanta; W. M. Harrison, Decatur; Hugo Robinson, Albany; B. V. Ilmore, Rome; H. L. Akeridge, Brunswick; B. D. Blackwelder, Gainesville; J. K. Payne, Americus; M. E. Winchester, Thomasville; and J. H. Hammond, LaFayette.

Weekly conferences at the University Hospital, Augusta, under the direction of the Public Health Nursing, are being held. The object of these conferences are to help the mothers keep their babies well. The babies are weighed and measured and the mothers are given instructions as to the feeding and care of these children. The public health nurses later visit the homes of these children to see that the instructions are being followed. Instead of one conference this year, three are going to be held, as the last one proved so successful.

Dr. W. C. Kennedy, City Health Officer for Atlanta, has announced the opening of a free clinic for the prevention of diphtheria among Atlanta children. This clinic is open every afternoon between 3 and 5 o'clock in the City Health Department.

Dr. M. A. Fort, Health Commissioner for Decatur, Seminole and Miller Counties, established three clinics in Bainbridge for the benefit of the flood sufferers. All drinking water was distilled and homes were scoured with lysol solution to prevent an epidemic of influenza, pneumonia and typhoid.

The members of the Jenkins County Medical Society administered typhoid vaccine free to every one who desired it three afternoons during February. This Society is composed of Drs. M. E. Perkins, Q. A. Mulkey, C. Thompson and H. G. Lee, all of Millen.

Dr. DeLamar Turner, Chatham County Health Officer, had all the people within the flooded area

in his territory vaccinated with anti-typhoid vaccine. One-thousand doses were ordered and the first week of February was set aside for this work.

There has been a marked decrease in contagious disease in Sumter County as was shown by the annual report of Dr. J. W. Payne, Commissioner of Health, read before the regular meeting of the Sumter County Board of Health. Dr. Payne's report shows that excellent work was done along all health lines in this County with wonderful results. It was decided to retain the public health nurse for Sumter County.

On April 6th, over 150 doctors from all parts of the South will be in Atlanta to attend the clinic of the Atlanta Graduate College of Physicians and Surgeons. Post graduate courses will be given in every department of medicine. The clinic will be conducted in the wards of the Grady Hospital. In the future, it will not be necessary for doctors to go to Baltimore or other northern cities for post-graduate courses. They will have to go no further than Atlanta for the Atlanta Graduate College of Physicians and Surgeons will be equal to any school in America. Southern doctors are striving to make Atlanta one of the country's outstanding medical centers.

The Little-Griffin Hospital, at Valdosta, caught on fire February 6th but was discovered in time not to cause much damage. The greatest loss was sustained from smoke and water.

The Fulton County Medical Society sponsored a Clinical Conference at the Steiner Clinic, February 2nd. Dr. William Stone, Director of the Memorial Hospital, of New York City, was the honor guest.

Dougherty County had the lowest death rate from typhoid during 1924, according to the report of Dr. Hugo Robinson, County Health Commissioner.

The death rate in America was lower in 1924 than it has ever been. For last year the death rate was 130,790; being 7,210 less than 1923.

Doctor's Exchange announces the removal of offices to 701 Ponce DeLeon Avenue, Atlanta. Telephone, Hemlock 6300.

Dr. Emmett Ward announces the removal of his offices from 65 Forrest Avenue to 421-422 Wynne-Claughton Building, Atlanta. Dr. Ward is a member of the Fulton County Medical Society.



### ATLANTA ACADEMY OF OPHTHALMOLOGY AND OTO-LARYNGOLOGY

The Atlanta Academy of Ophthalmology and Oto-Laryngology held its annual meeting January 29, 1925. The following officers were elected for the ensuing year:

Dr. H. M. Lokey, President

Dr. W. C. Lyle, Vice-President

Dr. Cecil Stockard, Secretary-Treasurer

The Academy meets regularly the 4th Thursday night of each month at the Academy of Medicine, 32 Howard Street. All visiting eye, ear, nose and throat men are always welcome.

CECIL STOCKARD, M. D.,  
Secretary-Treasurer.

### THE ASSOCIATION OF SEABOARD AIR LINE RAILWAY SURGEONS

The 21st annual session of the Association of Seaboard Air Line Railway Surgeons was held in Sarasota, Florida, December 9, 10, 11, 1924. Automobile trips, visit to orange groves, banquets, deep sea fishing, surf bathing, dancing, etc., were entertainments provided for the guests.

Dr. J. W. Palmer, of Ailey, and an Ex-President of the Medical Association of Georgia, has been Secretary-Treasurer of the Railway Association for 22 years. The members, as a token of their love, esteem and appreciation of his 22 years of service, presented him with an elegant Hamilton gold watch and chain and a large, beautiful loving cup.

### DIPHTHERIA ANTITOXIN FOR THE ITCH

Dr. G. Y. Moore, of Cuthbert and Secretary of the Randolph County Medical Society, was called in to see a four-year old child with diphtheria. This patient also had a severe case of itch. 10,000 Units of diphtheria antitoxin were given, but nothing was used for the itch. Within a day or two the itch commenced to dry up and within three weeks time there was not the slightest sign. Other children, who were suffering with it at the same time, still have it, although they are using itch remedies.

Dr. Moore is keeping this case under observation to see if there is really anything in horse serum or diphtheria antitoxin that will counteract the itch germ.

### BOOKS RECEIVED

**THE DIAGNOSIS OF CHILDRENS DISEASES** (With Special Attention to the Diseases of Infancy.), by Professor Dr. E. Feer,

Director of the University Children's Clinic, Zurich, Switzerland. Translated by Carl Ahrendt Scherer, M. D., F. A. C. P. Price \$3.00. Publishers: J. B. Lippincott Company, Philadelphia, Pa.

**OPERATIVE SURGERY** (Second Edition), by J. Shelton Horsley, M. D., F. A. C. S., Attending Surgeon, St. Elizabeth's Hospital, Richmond, Va., with 666 Original Illustrations. Price \$12.50. Publishers: The C. V. Mosby Company, St. Louis, Mo.

**AFRICAN HOLIDAY**, by Sutton. Price \$2.25. Publishers: The C. V. Mosby Company, St. Louis, Mo.

### BOOK REVIEWS

**CANCER—Nature, Diagnosis, and Cure** by Francis Carter Wood, M. D. Director, Institute of Cancer Research, Columbia University, New York; Director, Radiotherapeutic Department, St. Luke's Hospital, New York—The National Health Series, Edited by the National Health Council. Funk & Wagnalls Company, New York and London.

This is a splendid little book written by a man well qualified for the task. It is conservative and positive in its statements. As its title implies it covers the scope of cancer research in any way that the individual can readily understand, whether he is a student of medicine or political economy. The various means now known to science for curing cancer are given due consideration. The cancer "Sure cure quack" is dealt with in no uncertain terms and many of his schemes are exposed.

We take pleasure in recommending it to those who want a general knowledge of the subject.

J. L. C.

### MARRIAGES

Dr. William Randolph Smith and Miss Jean Douglas, daughter of Mrs. Hamilton Douglas, were married Wednesday, March 11, 1925, at the Liberal Christian Church, Atlanta. Dr. Smith is a member of the Fulton County Medical Society and has offices at 746 Peachtree street, Atlanta.

## Medical Progress

With the cooperation of our associates we propose to publish under "Medical Progress" abstracts from current medical literature of general interest to the

profession. Members of the association are invited to contribute to this Department.

Anderson, W. W., Pediatrics  
 Ballenger, E. G., Urology  
 Bartholomew, R. A., Obstetrics  
 Block, E. B., Neurology and Psychiatry  
 Clay, Grady E., Ophthalmology  
 Dowman, C. E., Neuro-Surgery  
 Eguen, M. S., Otology, Laryngology and Rhinology  
 Fitts, Jno. B., Internal Medicine  
 Greene, E. H., Surgery

Hodgson, F. G., Orthopedics  
 Holmes, Walter R., Gynecology and Female Urology  
 Jones, Jack W., Dermatology  
 Klugh, Geo. F., Clinical Pathology  
 Landham, J. W., X-Ray and Radium  
 Pruitt, M. C., Proctology  
 Thrash, E. C., Internal Medicine  
 Walts, C. E., Surgery

### TREATMENT OF PEMPHIGUS

Davis and Davis, in the November 1923 number of the Archives of Dermatology, published a paper entitled, "A Contribution to the Treatment of Pemphigus."

After reviewing the various types of pemphigus with a review of the literature as to prognosis and treatment they report a series of seven cases, with a clinical diagnosis of pemphigus treated as follows. Iron cacodylate, 1 gr. to 5 c. e. of vehicle injected intravenously every other day. In addition to the above coagulen 1.5 c. e. is given on alternate days.

Case No. 1. Pemphigus vulgaris, has remained free from symptoms 18 months.

Case No. 2. Acute septic pemphigus, has remained free 18 months.

Case No. 3. Pemphigus foliaceus, case cleared in 20 days.

Case No. 4. Pemphigus vulgaris, lesions clear after one year of treatment.

Case No. 5. Acute septic pemphigus, patient dies after six injections.

Case No. 6. Post-vaccinal pemphigus, condition satisfactory.

Case No. 7. Pemphigus foliaceus, has remained clear for two months.

As suggested in the discussion of this paper, the prognosis of pemphigus has been so hopeless up to the present that any such treatment as the above which throws a little more hopeful light on the prognosis of so a dread disease is a marked step forward.

JACK W. JONES.

### PROGRESS IN OBSTETRICS—1924

A review of the literature in obstetrics during the past year serves to impress upon one the fact that this important branch of

medicine has not lagged behind the other fields of medicine; also to what a great extent its advances are dependent on the well organized clinics in the larger medical centers, with their abundant clinical facilities, through which leaders in teaching, practice and research are continually being developed. The national and local societies, devoted to this specialty, as well as the special sections of the large medical societies, fulfill an important function in serving as a clearing house in deciding the merits and standards of treatment.

A proper evaluation of advances in obstetrics is not always possible until subsequent trial shall have established their worth, hence opinions here expressed are to be considered only in the light of present day knowledge. Furthermore, the scope of this review is not offered as exhaustive in its extent.

The diagnosis of pregnancy has been made a matter of indisputable record by the roentgen ray examination, whenever parts of the fetal skeleton can be demonstrated. Through refinements in technique a positive diagnosis is occasionally possible in a pregnancy three months advanced and should be practically always possible when pregnancy is six months advanced. Positive roentgen ray evidence leaves nothing to the personal equation, and is superior to the recognition of the fetal heart, fetal movements or fetal parts. However, to the practiced clinical touch, which should be the aim of all practitioners to develop, the diagnosis should seldom remain dependent on roentgen ray evidence. Other tests, depending on decreased sugar tolerance in early pregnancy,

or specific ferments in the maternal serum are not sufficiently reliable or practical to be extensively adopted.

The treatment of inevitable abortion complicated by fever continues to excite considerable controversy. The choice between active or conservative treatment should rest rather upon a consideration of the pathology of the disease, an appreciation of which should favor a conservative plan of treatment. Certainly Hillis' "Experience with 1000 Cases of Abortion" which appeared in *Surgery, Gynecology and Obstetrics*, January 1924, argues strongly against radical or active treatment.

The treatment of pernicious vomiting of pregnancy by the use of glucose solution intravenously, and Insulin hypodermically, as suggested by Thalheimer, in *Surgery, Gynecology and Obstetrics*, August 1924, has been attended by sufficiently favorable results to make it worthy of trial in every case. A final estimate of its real value must await the publication of larger series of cases.

Discussions of prenatal care continue to engage the attention of many authors. This phase of obstetrics is of such great importance from a preventive standpoint that too much can hardly be written on the subject. The recognition of syphilis and the toxemias of pregnancy are particularly emphasized. The fact is fortunately coming to be appreciated that a consideration of child welfare problems should logically be preceded by prenatal study, if we are to improve our results.

Much work has been done on the subject of blood chemistry in its application to the toxemias of pregnancy. The consensus of opinion seems to be that such analyses do not show sufficient changes to make them of value either from the standpoint of diagnosis or prognosis, except in case of nephritic toxemia where a retention may be found in the more severe cases.

The treatment of eclampsia shows a distinct trend toward conservatism, promoting elimination by catharsis, venesection, glucose or saline infusion; controlling the convulsions by morphine; inducing labor by the use of catheter or Voorhees bag and completing delivery when possible by forceps or version and extraction with the least possible shock to the patient. Statistics of cases treated conservatively, show a much lower mortality than among those treated by cesarean section or forcible dilatation and delivery. Eclampsia has almost been eliminated in clinics where patients receive adequate prenatal care.

Ablatio placentae is considered to have a better prognosis under conservative treatment giving the patient supportive treatment, rupturing the membranes, favoring dilatation if necessary by the use of a bag and stimulating contraction of the uterus and increased pressure by the use of pituitrin and an abdominal binder. Some authorities recommend transfusion and cesarean section for patients showing evidence of acute anemia and shock. However, it would seem, that such cases, usually in severe shock, are poor subjects for operation and have a better prognosis if treated for shock leaving the delivery to Nature aided by some of the simpler measures above suggested.

Placenta previa is coming to be regarded as a complication best treated by abdominal cesarean section, provided the patient is near full term, not infected, the baby in good condition, the proper facilities available, and the cervix undilated. In the earlier stages of pregnancy, with inadequate facilities or probability of infection present, or if the above conditions are not fulfilled, Braxton-Hicks version, preceded by the use of Voorhees bag, if necessary, is more suitable.

—R. A. BARTHOLOMEW, M. D.

(To Be Continued in April Journal)



## COMMUNICATIONS

## The Chiro's Are Getting Busy

To The Editor:

I am enclosing a letter that may be of interest to you.

Having a peculiar name—when the post office here gets any mail to whom they do not know to deliver it—I am the goat—hence got this one. It happens there is no such man here or near here.

Again note the starting word of the letter. I accused Dr. Hall of "joining up"!!

Thought this letter may be worth something to us. It seems this bunch is having some trouble getting funds—but that is no reason we should rest on our oars.

Fraternally,  
P. O. CHAUDRON.

Cedartown, Ga.

## Letter Referred to by Dr. Chaudron\*

Atlanta, Ga. Jan. 29, 1925.

Dr. \_\_\_\_\_

Cedar Town Ga.

Dear Doctor:—

\_\_\_\_\_ writes me that you have never renewed your membership in the State Association since returning to Georgia, and I can assure you that it was quite a shock to me, knowing that you were from New York State and was obliged to know the conditions that the profession are practicing under there? Now you must know that we cannot have a law and have it function unless it has an Association to back it up, and unless the chiropractors of Georgia do not come to the assistance of the State Association right away, and pay up back dues, and those that do not belong, join and help us out, we will all be looking for other pastures to practice, for we are over five hundred dollars behind in back dues at this date, and very little interest shown in the past two years, so I want you to send me as much as one year's dues at the least, and really, I think you should send this and last year's both, which is twenty dollars, and I want you to attend the next meeting which will be held in Macon in early April, and make yourself an active member, for we need you, and I am sure that you can be of great help to us, so come along with the dues, for it is really imperative.

Hope this finds you well and happy and as busy as you wish to be; my practice has started off just splendid this month, and I am sure we are going to have a good year in the profession.

Let me hear from you right away, with all good wishes, sincerely your friend.

\*Punctuation just as it appears in original letter.—Ed.

To The Editor:

I have just received the December copy of the Journal of the Medical Association of Georgia. I have just finished reading the very nice article of Dr. James A. Thrash, Jr., Columbus, Ga., and if I am not presuming and if you think it worth while, may I not hand you the following notes on the early diagnosis of tuberculosis from the twelve lectures delivered to a class of us January, 1917, at the New York Post-Graduate School and Hospital, 20th Street and 2nd Avenue, N. Y., by Dr. Abrams.

## THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS

Those liable to tuberculosis—patients with aortic stenosis or aortic insufficiency.

Not prone to attack—those with emphysema.

In mitral insufficiency you get congestion and consolidation of upper lobe. In bronchitis you get medium rales all over the lung. If the medium rales are confined to small area, that spells beginning tuberculosis. If small rales are at apex—then tuberculosis—nothing if small rales are at lower lobe.

Dry rales are subcrepitant and are always pathological—indicates inflammatory process in lung tissue—musical rales or moist rales are pathological.

In acute bronchitis you get sonorous rales in first stage. In bronchial asthma you get sonorous rales. In tuberculosis you sometimes get sonorous rales.

Tuberculosis if whispered sound is heard at the acromion process of clavicle. Just place the bell of your Ford stethoscope there—tight down on skin so as to exclude air of outside world. You can hear that whispered voice sound going up into the bell of your "scope." Tuberculosis is in the pleura if you have friction sounds at apex of lung. Tuberculosis is in the lung tissue

if you hear dry rales at apex. Tuberculosis is in the mucous membrane if moist rales are at apex. If tuberculosis is in the pleura it takes a number of years to see germs in sputum. If in the lung tissue you get tuberculosis bacilli sooner. If in mucosa you get the tuberculosis bacilli sooner.

Raise arm straight above head—if radial pulse is diminished or obliterated tuberculosis is on the side of the raised hand—if you can exclude mitral regurgitation, mitral trouble will give you an accentuation of the second sound.

The thermometer test: Shake your thermometer down to 95. Place it under skin of neck and shoulder you have pinched up to cover the mercury part. This of course in the afternoon. If there is a difference of 2-5 or more degrees in the two sides; you have an incipient tuberculosis on the higher side. Sign is no good in the advanced cases.

Medical treatment recommended to us:

(Place the thermometer and keep it in position for exactly five minutes.)

Rx

Guaiacol Carbonate	Grs	10
Arsenic Trioxide	"	1/40
Strychnine Sulph	"	1/30
Sparteïn or		
Digitalis	"	1/3 to 1/4

M. Sig. One pill after meals for ten days with the usual intermission account of the Arsenic. Keep this up a while every other year, etc.

L. F. LANIER, M. D.

Rocky Ford, Ga.

To The Editor:

Messrs. D. Appleton & Co., medical publishers of this city, some months ago, requested Dr. Gustav J. E. Tieck and myself, to prepare a work on plastic surgery. Considerable progress has already been made.

In our researches our abstractors brought to our attention a very excellent contribution on this subject, written by Doctor Benjamin H. Minchow, entitled, "Transplantation Flap Repair of Lower Eyelid Following Removal of Epithelioma."

This article appeared in your Journal in 1922. We are quoting from this article.

Will you kindly forward us a copy of the above mentioned publication and bill us for same.

Full courtesy will be credited to your publication in our book.

Yours very truly,  
DR. H. LYONS HUNT.

P. S.—We are writing to request permission to embody in our book the illustration contained in the above mentioned article.

New York.

To The Editor:

I am very grateful to you for your letter of February 6th, sending me a copy of letter from Dr. H. Lyon Hunt, of New York, in which he asked for a copy of the Journal in which a paper of mine, "Transplantation Flap Repair of Lower Eyelid Following Removal of Epithelioma" appeared in 1922.

It appears that Dr. Hunt wants to use some illustrations which probably do not appear in this article but appear in the reprint later.

I have sent Dr. Hunt a copy of the reprint which gives the illustrations splendidly.

Thanking you for your kind expressions, and with my personal regards to you, I am,

Yours truly,

B. H. MINCHEW.

Waycross, Ga.

Dear Doctor Bunce:

It might be of interest to you, as an official of the State Medical Association, to know that the jury returned a verdict for the defendant in the case of Mrs. F. L. B., against me for \$15,000.00.

It was a genuine pleasure to be associated with such sincere and efficient attorneys as Bryan & Middlebrooks. Mr. Middlebrooks handled the details of the case, and at all times showed a profound interest not only in winning this case for me but feeling that it would be a victory for the profession of the State. I heartily congratulate the State Medical Association for retaining this firm of lawyers.

With best wishes, I am,

Yours fraternally,

"A MEMBER."

January 28th, 1925.

To The Editor:

It was kind of Dr. C. K. Wall, of Thomasville, and you to extend me the courtesy of honorary membership in your Association.

I accept, with great appreciation, the membership card and thank you for your kindly personal expressions and offer of co-operation in the work which I have undertaken.

I am very sure that the JOHN D. ARCHBOLD MEMORIAL HOSPITAL is going to find a useful place for itself in Thomasville and Georgia and, for myself, the contacts which this membership offers me will be most helpful.

Very sincerely yours,

JAMES L. BEVANS.

February 13, 1925.

To The Editor:

We enclosed check for \$1.00 in payment of ad in January issue. We are pleased with the results

of this ad, as we have received several inquiries. As we have not yet closed a deal with any so far, we ask that this ad be inserted in the February issue also.

Yours very truly,  
WALKER DRUG CO.

Montezuma, Ga.

### OBITUARY

Dr. Robert Walter Trotter died from gastro-enteritis at his home in Madison, Friday, January 16, 1925, at the age of 68. He was graduated from the Southern Medical College (Atlanta) in 1889 and had been practicing in Madison for about 30 years, where he was prominent in professional, fraternal and church circles. Dr. Trotter was a native of Charlotte, N. C.

Dr. O. P. Tucker, a Postal Railway Clerk of Cuthbert, killed himself, Saturday, February 14, 1925, with a government pistol. He was an honorary member of the Randolph County Medical Society.

Dr. C. R. Mann committed suicide January 22, 1925, at the home of his sister in Perry. Dr. Mann had practiced medicine in Perry since 1868. He had served in the Confederate army throughout the war, having enlisted when 18. At the time of his death he was 79 years of age.

Dr. William McDonell died in Jacksonville, Florida, January 16, 1925, at the age of 43. He was at one time connected with the Macon Hospital and later was associated with the late Dr. H. J. Williams at the Williams Sanatorium, now the Middle Georgia Sanatorium. He was a nephew of Dr. Williams. In Jacksonville he was Chairman of the Board of Health of that city. He was a graduate of Mercer and Vanderbilt Universities.

Dr. W. S. Howard, a prominent and beloved physician of Experiment, was instantly killed by a northbound Central of Georgia train, January 14, 1925. He was a native of Dawson County and had been practicing in

Experiment for 9 years. Dr. Howard was a graduate of The Atlanta Medical College, a Mason and a past member of the Spalding County Medical Society. He is survived by his wife and two daughters.

### WANTED — ASSISTANT

Wanted—A capable assistant for general office and genito-urinary work. Office in the new Atlanta Commercial Bank Building, Marietta Street, Atlanta, Georgia. For particulars write D. A. B., c/o Medical Association of Georgia.

### WANTED—LOCATION

WANTED—Location in small town Thoroughly experienced in Internal Medicine, Obstetrics, Tuberculosis, Roentgenology and Surgery. Thirty-two Years of age, unmarried and German by birth. Has studied at the best Universities in his country and was graduated in 1920 from Class A University. Address F. H., care Medical Association of Georgia.

### WANTED—PHYSICIAN

Wanted—General practitioner. One who can do good laboratory work in connection with regular practice, who makes a good appearance, who wants to find a good and remunerative opening in progressive Florida town. Write G. A. D., Care Medical Association of Georgia.

### WANTED—LOCATION

Wanted—Location in small town of 2000 to 5000 population that is really in need of a conscientious, hard-working physician. Graduate of A-1 college and has had one year as Intern. Can furnish the best of references. Write P. H. S., Care Medical Association of Georgia.

Dr. Marion C. Pruitt opened up offices in the new Wynne-Claughton Building, Atlanta, March 15th. Dr. Pruitt formerly had offices at 65 Forrest Avenue. He is a member of the Fulton County Medical Society and has been Business Manager of the Journal for the past 5 years.



**ABSTRACT OF THE MINUTES OF THE  
MEETING OF THE BOARD OF TRUS-  
TEES OF THE A. M. A., HELD AT  
HEADQUARTERS, CHICAGO,  
NOV. 20-22, 1924**

(Continued from March Issue)

**Bureau of Legal Medicine and Legislation**

The report of the executive secretary of the Bureau of Legal Medicine and Legislation was received and considered.

It was decided to increase the personnel of this bureau in order that the greater demands that are being made on it might be more effectively met.

The executive secretary of the bureau submitted to the Board a proposed bill to amend the National Prohibition Acts. This bill, prepared in accordance with instructions received from the House of Delegates, provides: (1) for the amendment of the National Prohibition Acts so that the limitation now imposed whereby only 1 pint of alcoholic liquor can be prescribed within ten days shall be removed from the act; (2) for the amendment of the act so that a physician will not be required to keep records,

open to inspection by a considerable group of federal and state officials, showing the purpose or ailment for which he had prescribed liquor, and that he cannot be compelled to disclose such information except under subpoena in a court of law, subject to the general provisions of law relating to privileged communications; (3) to amend the act so that a physician will be required to prescribe, so far as may be practicable, in quantities susceptible of being dispensed in unopened, bottled-in-bond packages; (4) to amend the act so that the pharmacist must dispense bottled-in-bond packages, so far as may be practicable; (5) to amend "An Act Supplemental to the National Prohibition Act" so as to permit the prescribing of malt liquors; (6) to permit a physician to prescribe any amount of liquor at any time; (7) to permit a physician to prescribe as frequently as he sees fit, subject, however, to the provision in Section 7 of the National Prohibition Act that he can prescribe only "after careful physical examination of the person for whose use such prescription is

(To Be Continued)

## THE ATLANTA GRADUATE SCHOOL OF PHYSICIANS and SURGEONS

### ATLANTA, GA.

*Announces—*

#### Short Time Courses, Beginning April 1, 1925

**UROLOGY**

Prof. Montague L. Boyd  
and associates

**GENERAL SURGERY**

Prof. T. C. Davison  
and associates

**OPERATIVE GYNECOLOGY**

Prof. Garnett W. Quillian  
and associates

**ENDOCRINOLOGY**

Prof. Arch Elkin  
and associates

**INTERNAL MEDICINE**

Prof. E. C. Thrash  
and associates

**TECHNICIAN COURSES**

Anesthesia, X-ray and laboratory  
courses can be arranged

*For Information Address*

### THE PROCTOR

Atlanta Graduate School of Physicians and Surgeons

101 North Butler St., Atlanta, Ga.

# THE JOURNAL

## OF THE

# MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL PROFESSION OF GEORGIA

PUBLISHED MONTHLY under direction of the Council

Volume XIV

Atlanta, Ga. April, 1925

No. 4

## Original Articles

### THE TREATMENT OF DIABETES\*

J. D. Gray, M. D.,  
Augusta, Ga.

During the past twelve or eighteen months much has been written on the treatment of diabetes, with special reference to Insulin. Little has been said about treatment without Insulin, or about prevention of diabetes. These are both very important factors and so many cases of diabetes do not need Insulin that treatment without Insulin, as well as treatment with Insulin, should be carefully considered. This is especially true when one thinks that about 5 per cent of diabetics are severe cases and that the percentage of mild cases to the total number of diabetics is increasing. This was shown by Joslin in 1915; of the last 100 cases, 12 were severe, 52 moderately severe and the remaining 36 mild. The last 100 prior to March 1, 1917, 8 were severe, 47 moderately severe and 45 mild. In 1923, 100 consecutive cases showed 2 severe, 21 moderately severe, and 77 mild. With these facts it will clearly be seen that the treatment of mild cases is very important. Some of these will require Insulin, most of these will not.

A normal person at rest requires 25 to 30 calories per kilogram body weight; at light work he requires 35 to 40 calories; at moderate work 40 to 45 calories; at hard work 45 to 60 calories per kilogram body weight. It is interesting to know that there is 20 per cent more energy exerted sitting on a chair than lying on a couch, and if asleep

lying, and awake sitting, there is a difference of 30 per cent to 40 per cent. Children require more calories per kilogram than adults.

Men at rest eliminate about 25 calories per kilogram per 24 hours. It is very difficult to estimate caloric requirements. The percentage of error is between 10 per cent and 20 per cent. This can readily be understood in watching individuals; some sit very quietly and others are very restless.

We all know that a calorie is the amount of heat necessary to raise 1 kilogram of water 1 degree Centigrade. To give an idea of a calorie Professor Benedict says: "there is one calorie of heat expended to rise from a sitting position in front of a door, turn the key and sit down."

A normal American takes in 24 hours 100 gms. Protein, 400 gms. Carbohydrates, 100 gms. Fat. That we can live on much less Carbohydrates is shown by the Eskimo, who takes 50 gms. Carbohydrates, 280 gms. Protein, 140 gms. Fat. Europeans take more carbohydrates and proteins than Americans, but less fat. Many people live on very low protein diets. This is shown especially in nephritics two-thirds of a gram per kilogram is considered the minimum.

Fat occurs more frequently in pure form; cream, butter, and oils are the more agreeable varieties. The chief source of error in estimating a diet is the estimation of fat. Some fish are very low in fat—such as cod, flounder; then others have a great deal—salmon, shad, etc. In the process of cook-

\*Read before the Augusta (1924) meeting of the Medical Association of Ga.

ing, fat is lost in a varying degree. The fat of cooked bacon varies from 37 per cent to 79 per cent. Eggs contain, usually considered, 6 gms. protein, 6 gms. fat. Eggs vary in weight from 12 per cent to 55 per cent. The weight of an egg shell is 7 gms. These facts should show that neither doctors, nurses, nor patients should take the calculation of calories too seriously; the grams of carbohydrates, proteins, and fat, and calories should not be recorded in decimals but in round numbers.

We know that usually a normal person takes about 500 gms. carbohydrates in 24 hours. It is rare that a diabetic can take more than 100 gms., which shows a decrease of 75 per cent. Character of carbohydrate has little effect on assimilability, with the exception of levulose. Levulose given in fairly large quantities does not cause a material increase of blood sugar. The explanation of this is probably that normally the tissues store up large quantities of glucose and in a diabetic are more or less saturated. There is very little levulose stored up because there is very little taken and the tissues are able to take up and store large quantities so that it is not present to a very marked degree in the venous blood.

It is very difficult to estimate the diabetic's requirement as there are many people that live on less than 30 calories per kilogram.

The carbohydrate value is usually estimated as the carbohydrates plus 58 per cent protein, plus 10 per cent fat.

Fats comprise a large part of a diabetic's diet, although fats make up a small percentage of a normal diet. It is not exceptional to find that the fat makes up  $\frac{1}{2}$  the total calories and as much as  $\frac{3}{4}$  or  $\frac{8}{9}$  has been given. Fat is the chief source of acidosis; though to a lesser degree, the amino acids of the protein molecule with even numbers of carbon atoms contribute. If the urine is sugar free, acidosis is not likely to occur if the fat is twice the carbohydrates, or thrice the carbohydrates, if the protein is 1 gram per kilogram. Only fatty acids with an even number of carbon atoms give rise to diacetic acid. Fatty acids in the course of

oxidation in the body lose 2 carbon atoms at a time. There is a rapid oxidation of fats to butyric acid and later to  $\text{CO}_2$  and  $\text{H}_2\text{O}$ , if there are sufficient carbohydrates. In diabetics the fats are broken down to butyric acid, then to oxybutyric acid and later to diacetic acid. It was seen that if a fat with an odd number of carbon atoms could be made then acidosis would not occur. It was left to Dr. Max Kahn who from stearic acid made margaric acid with a formula of  $\text{C}_{16}$ ,  $\text{H}_{33}$ ,  $\text{CO OH}$  and called it Intarvin. This substance is of a white creamy color, odorless, tasteless—melting at 38 degrees Centigrade, neutral in reaction. It has been used in some severe cases with success.

### Treatment—Prevention

It is estimated that there are over one million diabetics in the United States. Therefore it is necessary to try to prevent diabetes as well as tetanus, diphtheria, typhoid, etc. To do this it is necessary to treat very energetically those with the slightest evidence. Many times patients with a mild diabetes have been seen—only a little sugar found in the urine, and this soon eliminated by dieting; later this same diabetic became a severe one. All those susceptible should be seen, their urine examined and a blood sugar determination made. We know that diabetes, to a certain extent, is a familial disease. Often it is latent, developing in children before it develops in the parents.

An early diagnosis is very important. It is often said that the first year of a diabetic's life is the dangerous time. Early diagnosis can be accomplished by frequent examinations of the 24 hour specimens of urine, and blood. Dr. John insists on a routine blood sugar on a fasting stomach. It may soon be that all internists will insist on a blood sugar determination as well as a Wassermann test.

It would be well if everybody would have a yearly examination of the urine on his birthday, or Christmas, or Easter, or some certain time. Education of patients with diabetes will afford recognition of the symptoms in others and often will be the cause



of examination of the urine or advice to see a doctor immediately.

Some one has said that all fat people are potential diabetics. Just as undernutrition is good in treatment, it is just as good in prevention. It would be well for all people over 36 years of age to be 5 per cent to 10 per cent underweight. So many people think that they could not have sugar in the urine as they are gaining weight but sugar may be in urine while gaining weight.

The urine should be examined often during all infectious diseases. Often diabetics tell you of being well until they had "flu" and a few months after having had the "flu" they had sugar in the urine. All foci of infection especially an infected gall bladder with or without stones, should be cleared up. Often after a cholecystectomy for gall stones or cholecystitis, the patient has entirely recovered from diabetes.

Pregnancy—If all women, during pregnancy, would have the urine examined often, sugar would no doubt be found in a large percentage of patients. This does not necessarily mean diabetes, but with a small percentage of sugar constantly in the urine, especially if on a diet of not more than 100 gms. carbohydrates, one should be anxious. Of course a blood sugar determination would be very valuable.

A Harvard professor once said that "mental work makes sugar. Manual work burns it up." A diabetic before treatment becomes depressed but with the institution of treatment, especially with Insulin, this is soon overcome. Heavy responsibilities should be avoided as well as nervous upsets and all excitements. Diabetics should get a certain amount of exercise. It lowers blood sugar. This is very clearly shown by reactions if taking Insulin with exercise.

Syphilis has not always been considered an important etiological factor in diabetes. I think if a diabetic has syphilis, this should be very energetically treated along with his diabetes because a few cases recover from the diabetes. Only recently Dr. Paullin has reported some cases.

### Treatment

Diabetics are usually divided into mild,

moderately severe, and severe cases. Some cases which appear to be severe may run a favorable course and cases that appear to be mild may be very intractable. Diabetes in children is usually severe, but some are mild. Severe cases tolerate 0-10 gms. carbohydrates, moderately severe 10-50 gms., others are mild. On a diet of 1 gm. carbohydrate, 1 gm. protein, and 2 gms. fat, per mild; if less than 30 units of Insulin are required to keep sugar free, the cases are mild if less than 30 units of Insulin are required, they are moderately severe; if more than 30 units, severe. Acidosis is not a satisfactory basis for classification, because mild cases can be made to have acidosis by increasing the fat.

At the beginning of treatment the patient should be told that he is to be treated for life, so that the treatment can be adjusted without harm. The reasons for treatment should be told. It should be shown that they are wasting lots of sugar. They should be taught the urine tests, especially for sugar and diacetic acid. Patients should keep a notebook marking the number of calories, amount of carbohydrates, protein and fat, times they have sugar, etc.

Formerly, not over a decade ago, carbohydrates was the only food element regulated. Undernutrition was in vogue. Still later Newburgh and Marsh advocated a high fat diet and Woodyat showed that the fat could be as much as twice the carbohydrates plus one half the protein.

Mild cases should be very energetically treated. Their weight should be reduced to 10 per cent below normal. They should examine the urine regularly and a blood sugar determination should be made often. This prevents the mild cases from becoming severe.

There are several methods for calculating a diabetic diet.

Wilder's method is  $C$  equal  $0.24 m$ , minus  $0.41$  Protein, and  $F$  equals  $4 C$  plus  $1.4$  Protein.  $C$  equals Carb.,  $M$  being the caloric requirement,  $P$  the Protein and  $F$ , fat. Joslin gives 1 gm. carb. 1 gm. Protein, 2 to 2.5 gms. fat per kilogram body weight.

This is a very easy and practical method.

Dr. Campbell gives the following formula:

$$P \text{ equals } \frac{23}{30} \text{ gm. per Kg. body weight.}$$

$$C \text{ equals } \frac{M-10P}{10}; F \text{ equals } \frac{M-P}{2}$$

M equals the caloric requirement. P, Protein, C, Carbohydrates. F, Fat.

Woodyat has shown that when the fatty acid, glucose, ratio exceeds 1.5 to 1, ketonuria develops. In some people the ratio may be 4 to 1, but on such a diet they should be carefully watched.

The glucose is estimated by the formula—

$$G \text{ equals } C, \text{ plus } 0.58, \text{ plus } 0.1 F.$$

The fatty acids are estimated by the formula:—

$$FA \text{ equals } 0.46 P \text{ plus } 0.9 F.$$

Evans has estimated several formulae in the safety zone as follows:

$$\frac{FA}{G} \text{ ratio } 1/1. F \text{ equals } 1.25 C, \text{ plus } .15$$

$$P. C \text{ equals } \frac{Cal-5.4P}{15.3}$$

$$\frac{FA}{G} \text{ ratio to } 1/5 \text{ to } 1. F \text{ equals } 2 C \text{ plus}$$

$$.5466 P. C \text{ equals } \frac{Cal-8.9P}{22}$$

$$\frac{FA}{G} \text{ ratio } 2/1. F \text{ equals } 2.857 C, \text{ plus } P.$$

$$C \text{ equals } \frac{Cal-13P}{29.7}$$

These are simple formulae and the one I commonly use is:

$$F \text{ equals } 2 C \text{ plus } .5466P. C \text{ equals } \frac{Cal-8.9P}{22}$$

$$\text{This gives } \frac{FA}{G} \text{ equal } \frac{1.5}{1}$$

If a diet is calculated by either two of these methods there is not a wide difference.

The diet is calculated according to the caloric requirement. If one wants the patient to lose weight it is well to begin on about 20 calories per kilogram body weight. It is no longer necessary to starve a diabetic. If the diabetic is of about normal weight, more calories per kilogram can be given according to the amount of weight desired, and the amount of exercise taken. After about three or four days of such a diet, if the patient is not sugar free, Insulin is begun.

It must be remembered that Insulin is not an innocuous placebo (like many of the endocrine products with which we have been deluged of late), but a powerful drug. It is therefore as dangerous as morphine, when used improperly. It is more difficult to estimate the dose of Insulin because it involves not only the amount of Insulin, but the amount of food sugar taken. Food and Insulin should be nicely balanced, because if inadequate, glucose is available and we have a condition simulating surgical shock in some respects from which the patient may not recover. The symptoms of Insulin shock, Hypoglycemia, or Hyperinsulinism, are characteristic. The first symptoms are fatigue, drowsiness, anxiety. Then appear tremors, sweating, rapid heart action and dyspnea. Spontaneous recovery may occur, provided the disbalance between the Insulin and available glucose is not too great; otherwise delirium, convulsions, and death can only be prevented by the prompt administration of glucose. In order to avoid such accidents you must balance Insulin with food of known glucose value. You should take into account that not only sugars and starches but 58 per cent of the Protein and 10 per cent of the fat is utilized as glucose. Thus if we are to know how much glucose the patient is getting, the food must be weighed and the diet planned to contain precise quantities of carbohydrates, fats, and proteins. This involves the use of accurate scales and tables of food value, and careful planning, but it is not too complex for children from 10 to 14 years of age.

There are several ways to calculate the dose of Insulin. One method is to estimate the total glucose in the diet by taking the carbohydrates plus 58 per cent P, plus 10 per cent F, and subtracting the glucose excretion in the 24 hour urine. Calculating that one unit of Insulin will metabolize 3 to 5 gms. carbohydrates, the dose is calculated by the difference in the amount taken in and in the amount excreted. Insulin is then increased, if urine is not entirely sugar free, or if the blood sugar is yet high. The safest method and the one I prefer is that

of Joslin. One unit of Insulin is given before breakfast, two units before dinner, three units before supper—the urine being examined one hour before and one hour after each meal—and the dose of Insulin increased until the urine is sugar free one hour after meals. This dose is then given three times daily, or the daily amount is given half before breakfast, and half before supper. The dose of Insulin is then increased until the blood, fasting, is about 150 mgs. By this method I have never seen a reaction, although the reactions are easily controlled, and I have been able to keep the blood sugar between 120 and 180 mgs. That this is the most desirable method is shown by Dr. Joslin's case, who had a tolerance of 114 gms. carbohydrates and one unit caused the blood sugar to fall to .03 per cent. Allen reported a similar result with one half unit. Of course this was before the unit was so well standardized as it is now. It would be too much to hope to keep the blood sugar normal. The rendering of the urine sugar free is not the whole object; to keep the blood sugar down is very important. The urine of many patients will be sugar free and yet they will have a high blood sugar. This was shown in a case recently treated, who had a blood sugar of 280 mgs. on a fasting stomach and 2 per cent sugar 24 hour specimen. On a diet of 20 calories per kilogram he became sugar free with a blood sugar of about 231 mgs. This patient had diabetic gangrene on his right great toe and a blister on the toe next. By giving him 10 units of Insulin daily we have kept him sugar free and with blood sugar between 120 and 140 mgs. His toes have entirely healed.

Regardless of the amount, Insulin is given subcutaneously, or intravenously, from 15 minutes to one hour before meals. It is most commonly given subcutaneously. The number of doses vary from one to three daily. I have seen two patients who required a dose before each meal and at night. One was a woman who took 20 units before each meal and at midnight 10 units. The

other was a little girl nine years old who had had diabetes for three years. She required 4 units before each meal and 2 units at 3.00 A. M. to keep the urine sugar free.

There are some cases on record who took as much as 50 units of Insulin daily, and still had traces of sugar in the urine and blood sugar normal. Eleven units daily is the average dose. Some of the mild cases, that is the cases who are kept sugar free by diet, do much better with small doses of Insulin. They have a sense of well being not only in strength but in weight and spirit.

A word about diabetic coma: A case with severe coma should be in the hospital. Rest and quiet, warmth to the body and extremities, 150 cc fluid per hour should be employed. Bicarbonate of soda may be used in 20 gm. doses, by mouth, or 5 per cent solution by rectum. Evacuation of the lower bowel is very important and should be accomplished by enemas. 40 units of Insulin should be given subcutaneously. It is not necessary to give glucose at this time because there is already so much in the tissues. If the case is of extreme severity Insulin may be given intravenously. If the Insulin is given intravenously, glucose should also be given. It is best given intravenously in a 5-50 per cent solution. Later glucose may be given by mouth when the patient has reacted. The next dose of Insulin will depend on the condition of the patient, amount of sugar in urine and blood. The urine should be examined every two hours for sugar and diacetic acid, if it is necessary to use a retention catheter. Blood sugar determinations should be done just before each dose of Insulin. It is usually necessary to give 20 to 30 units of Insulin every four to six hours with 20 to 30 gms. glucose for four to six doses. After this not less than 40 units daily for two or three days until the patient can take a maintenance diet. The size of the dose is then decreased and the interval of injection lengthened according to the symptoms and chemical findings.



**Discussion on Paper of Dr. J. D. Gray**

DR. J. W. DANIEL, Savannah. I regret that I did not have the pleasure of hearing the entire paper, but I wish to stress one point and that is that the mere fact that there is no over-flow of sugar in the urine have many patients referred to me with the urine sugar-free who are still very bad diabetics. We must remember that there is a variable threshold. We will find many patients, especially among the younger individuals, that have a very low threshold that will overflow with very little blood sugar, some with as low as 100 mgms. and some with 500 mgms. will have never a particle of urine sugar. One patient with an acute appendix who was operated upon never got union of the wound and died from exhaustion but never had a particle of sugar in the urine.

Another thing that will be noticed about diabetic patients when you are treating them is that notwithstanding that you are giving them insulin, and notwithstanding that they are on a fixed carbohydrate and fixed glucose intake per day, you will notice that you can tell almost to the minute when they will be developing some intercurrent disease. They will run along for days on some definite amount of glucose and then something will happen and you will know that within forty-eight or seventy-two hours they will develop some intercurrent disease, maybe a bad cold or measles. That shows that we go back to metabolism, or what we call resistance in even a healthy person, and when we fall down on the metabolism we become subject for disease.

There is a clear indication that one can harbor germs all through life and never have any trouble until something happens, and that "sometimes" is a failure of metabolism. It has been found that the younger the patient the more insulin has to be given. I have one little patient who came in with a cystitis and a blood sugar of about 180 mgms., with an overflow of about 15 grms. a day in the urine. That child is now taking sixty units of insulin a day on a 100 gram glucose intake and yet once in a while she still overflows. It took a year of constant treatment to accomplish any perceptible gain in weight. Adult patients require less glucose the later in life they manifest the symptoms of diabetes, but unless they are in extremis, where they are getting gangrene and so on, the easier they are to manage, the higher their tolerance, then the less glucose and insulin they take, but when we have them in extremis we have

to run the insulin up and even then we lose some of them in spite of everything we do.

DR. E. C. THRASH, Atlanta: Diabetes from the standpoint of treatment by the physician is pretty well understood. We must take into consideration that the treatment is a question of educating the patient. The patient must be told that he has an incurable disease, that he has not an organic inflammatory process, but that he has a disturbance of his organism so that he has a disturbed, and perverted or disordered metabolism, and so cannot metabolize carbohydrates. Let that patient go to school, as it were, and you become his instructor. Give him a book on diabetic diet and give him lessons in this book as to the proportions for his diet, give him scales to weigh his food, let him find out how many calories of each kind of food he gets, and let him shape it so that his urine will be sugar-free. You look after his blood and see that that is in good condition. You can check up with him occasionally. Let him get a fermentation tube and some yeast and he can keep up fairly well on what he is doing. It is all a matter of education. He cannot be coming to you all his life. The treatment depends upon the degree of intelligence the patient has, the degree of co-operation you get. If he is intelligent he will soon know every phase of diabetes. He will learn that the taking of the carbohydrate-free diet does not always relieve him, that he will get sugar from the other foods. He must learn how to balance his diet, how much carbohydrate, how much protein and how much fat it should contain, and he will go on and live to a ripe old age. You shall be his adviser. He should come in once in a while for examination of his urine and blood. These patients must be taught to manage themselves. They should be told to watch themselves carefully and whenever they run upon the breakers to come and see their physician. They should be told that if they have not sense enough to look after themselves they will break down, go into coma and probably die. That if they will carry out your instructions and learn how to eat the proper food in the proper amounts, and learn how to check up from time to time, that there is no reason why the diabetes should impair their health to a great extent. This applies to adults. Children are much harder to relieve than are adults for they are sick and cannot be taught to manage themselves so well.

DR. LOUIS F. LANIER, Rocky Ford: I have a young man just twenty years old with diabetes of three years standing. How much longer he has had it I do not know. I have great difficulty in getting him to look after himself. He has Joslin's book. His mother is intelligent and helps me as much as she can. As long as I can make him diet himself I can keep him sugar-free but he has been in school at Mercer for two years and has not followed his diet as well as he should. Last Christmas he came home with the urine sugar 4.8 per cent and with .3% blood sugar. I have been trying to get him to take insulin. He said the other day that he would take some pretty soon.

I wish to know how to manage these fellows. I cannot get them to come into the office. I have been trying since December to get this boy to come in so that I can find out what his blood sugar is but have not succeeded.

This boy is doing office work apparently without much fatigue. Had it not been for his Life Insurance Examination he would still be ignorant of his diabetes.

DR. J. M. ANDERSON, Columbus. I take it for granted that the majority of men who are here this morning would like to know what to do for their diabetic patients. In an average practice of twenty-five years I have had six patients who had unmistakable diabetes. Whenever any new product comes into the medical profession it is a tendency of the profession to take it up, not only from the standpoint of trying to help themselves but because the public demands it and they preach and talk about it all the time. In my opinion, the only thing to do with the markedly diabetic patient is to send him to school, as Dr. Thrash said. What is the use to take all of our limited time in trying to teach the diabetic patients what to do? Why not send to some one of the men in the big centers of the State? Tell the patient to go and study and stay with them for a little while and these men who make this disease their specialty, or at least devote a great deal of time to it, can teach them in a little time just what to do. There is no use in the average doctor trying to teach diabetic patients what to do. They should be sent to the men in the larger centers and allowed to get their education there. We all have patients who cannot afford to pay much but your doctor friends will be glad to help you out, and will teach them how to take care of themselves. I do not do this and

do not wish you to think that I want your patients sent to me, but send them where they can be taught to care for themselves.

DR. J. D. GRAY, Augusta, (closing): I only wish to say that we certainly have to have the co-operation of these patients. In reference to Dr. Lanier's patient, I think if I had a patient who would not do any better than that I would tell him to go to the devil. I have a patient who says every now and then, "I am not going to take this any longer," but I tell him to go ahead and get more insulin and by persistence I am able to keep him going. There are a few patients that I really do not think are able to go to the centers where much diabetic work is being done, and for those it certainly is a proposition to know what to do. They can be given one gram of carbohydrate, one of protein and two and a half of fat, in some cases, and for those who are not able to go to the men who do a great deal of this work I think this is the safest method. By giving insulin by Joslin's method, beginning with one unit and increasing until they are sugar-free, I think they are pretty safe.

### GAS BACILLUS INFECTION\*

Julian K. Quattlebaum, M. D.,  
Savannah, Ga.

In prebacterial days, the presence of free gas in parts of the body where it does not normally occur and in association with various affections was attributed by most observers to the penetration of air into the tissues, particularly of adipose tissue and bone-marrow brought by injury into contact with the atmosphere. Others considered it a form of putrefaction. In 1871 Bottini demonstrated the infective nature and transmissibility of the condition, and in 1893 E. Frenkel clearly showed the etiological relation of the gas bacillus to gaseous phlegmon.

When in 1891 Welch of Baltimore reported his observations and experiments to the Johns Hopkins Medical Society, and described the organism which bears his name, the question as to the origin of such gas was largely solved, and discussion turned generally to the method of best coping with this

\*Read by title before the Medical Association of Georgia at Augusta, May 9, 1924.

condition, for the presence of gas in the tissues has always caused great anxiety to the surgeon, and its association with a high mortality rate has been recognized from the beginning. Although this subject relates to rather infrequent affections and has always been more common in military surgery than in civil practice, cases of this most dreaded of wound complications are apparently more frequent today than ever before.

Various names have been given to this disease since the classical clinical description given by Maisonneuve (1), who designated it as "Gangrene Foudroyante" and of Pirogoff (2) who called it "Aente Gangrenous Oedema." Other names are "Emphysematous" or "Gaseous Phlegmon," "Septic Emphysematous Cellulitis" and "Gas gangrene."

### **Incidence**

No accurate statistics as to the incidence of the disease in civil practice are available. While comparatively infrequent, a city the size of Savannah will see perhaps a half-dozen cases in a year. It occurred with great frequency among the wounded in the recent war. While reliable figures were difficult to obtain, the percentage varies from about 5% as given in a particular casualty clearing station in the Bethune area in 1915, to figures collected from the French and German sources which put the percentage between 2% and 13%. All of these are perhaps high, and a percentage of something over 1% of the wounded arriving at the casualty clearing stations is nearer correct. Mairesse and Regnier (3) of Paris in 1918 reported that 297 of 1016 wounded men passing through their ambulance service showed the presence of bacteria of the gas producing group, in swabs made from the deepest part of their wounds as soon as the patient got in, and of this 297, 25 developed gas gangrene. J. L. Stoddard (4) in 1918, obtained by culture organisms of the *Bacillus Welchii* group in 23% of 132 consecutive wounds, definite gas infections occurring in 2.9% of them.

### **Bacteriology and Pathology**

Until the recent World War, the *Bacillus Aerogenes Capsulatus* (Welch Bacillus) was

thought to be the sole cause of gas infection. The investigation brought on by the enormous number of cases among the wounded, showed that pure infection of war wounds with this organism was so rare as to be almost negligible, other spore bearing anaerobic bacilli being commonly present in cases of gas gangrene. The *Bacillus Oedematis Maligni* (*Vibron Septicue*), the *Bacillus Bel-lonensis* and the *Bacillus Sporogenes* were the most frequent as well as the most pathogenic and dangerous of the group.

There is still considerable uncertainty as to the number and nature of the organisms responsible for gas gangrene. They are all perhaps fecal in origin with natural habitat in the intestinal canal and soil and hence widely distributed in nature, and found in human beings on various conditions. It probably not infrequently gains access to wounds without securing foothold.

Whether this group of germs is merely a saprophytic concomitant of an infectious process brought about and maintained by other pathogenic organisms, as is held by some investigators, or whether tissue destruction is due to the mechanical action of the gas formed, as is quite improbable, or whether they possess invasive powers of their own, is not definitely known. While it is not conclusively accepted that this group of germs is toxin producing, it appears that form or poisoning from the local action of the bacillus arises, and the belief is held that gas gangrene of muscle is essentially a manifestation of anaerobic infection, extreme trauma and the complex of shock, hemorrhage and exhaustion playing an important part as an etiological factor. While considerable doubt has been thrown on the view that it is essentially a muscle disease, the experiments of Bull (6) and others have shown that muscle tissue does play an important part in the development of the toxin and also in the spread of the disease.

By cultivating the germs anaerobically in broth to which sterile skeletal muscles of pigeons or rabbits had been added, a very intensely toxic fluid was obtained. This fluid produced intense edema, muscle degen-



eration and death within a few hours when injected into animals. This toxic fluid was differentiated into a hemolysin, destroying the red blood cells and another poison which did not act on the blood directly. Other experiments also place this class of germs in the toxin producing group and ascribes to them invasive and destructive properties of their own, which are probably directly responsible for many of the several phenomena observed in connection with such wound infections.

No satisfactory explanation has been made as to what kills the tissue, why the disease progresses in some cases and not in others and why it sometimes returns after amputation and why in certain cases treatment fails to cure the disease.

Tissue death seems to be a necessary antecedent to the spread of bacteria, and it is easy to understand the increase of the infection in a muscle already deprived of its blood supply. The view that the gas is formed by fermentative action of the organisms on the glycogen in the muscle tissue is undoubtedly correct. However, it probably plays a secondary role in tissue death by producing a tension in the part which interferes with the blood supply, and not by any disruptive effect on the muscle itself. Others believe the toxins evolved by the growth of the anaerobes contain a myolytic substance, an acid and probably deleterious disintegration products, in addition they possess anti-chemiotactic properties towards leukocytes. These observers trace the lytic changes through a number of stages from the blurring of the muscles to complete disintegration. The studies of McNeer and Dunn (7) show almost conclusively that the toxic fluid similar in constituents to the edema which also to a greater or less extent accompanies gas gangrene, spreads along between the interstitial tissues and the muscle fibres killing the fibres as it advances. Once the fibres are dead the germs remain there and live on the dead muscle producing gas. The toxic fluid which spreads is formed in the gangrenous tissues behind. The presence of the organisms is without effect on living tissues,

and they can quite often be found in healthy tissues in advance of the gangrene. This toxic fluid may be a true bacterial toxin, or something dependent on the breaking down of tissue. These phenomena interfere with the circulation through the muscles in advance of the process and leave to the rapid advancement of the gangrene. In case of arrest and recovery regeneration of muscle is extremely improbable. The absence of any reaction is one of the most striking phenomena of the advance of gangrene.

The disease is peculiar in that the infection finds difficulty in passing from one muscle to another. However, it easily spreads longitudinally and extends up and down a muscle from end to end. The muscle or muscles involved change color and usually become brick-red although this is influenced by the predominating type of organism. About this time gas becomes apparent and can be passed up and down between the fibers and crepitation can be elicited. The muscles become green or yellow, and its substance becomes friable, filled with white, yellow or blood stain edema. The interstitial tissues remain in stringy shreds. The gas often extends into the subcutaneous tissues, at times far beyond the limits of the disease, having followed the trunks of the main vessel or smaller branches along its ramifications. The gangrene may be limited to a single muscle or single group of muscles, either with or without injury to blood supply, or it may take on massive form and all the groups of a limb distal to the complete arterial lesion may die and become infected.

The color of the edema, the amount of gas formed, the color of the muscle and the odor, as well as other characteristics of the disease vary somewhat with the infecting agent. The *Bacillus Welchii* produces considerable gas with edema of yellowish tinge and muscles soft in consistency and of a dirty brick-red color. The odor has been described as being sourish. The *Bacillus Bellonensis* has practically the same characteristics. The *Bacillus Oedematis* is characterized by rather colorless gelatinous edema with muscles of lighter color than the other infections.

The *Bacillus Sporogens* has the quite characteristic putrid odor and olive green or black color of the muscles.

#### Method of Inoculation.

In war wounds the infection was directly implanted by the bits of clothing, fragments of shell, germ laden soil and the skin itself. Any wound might become infected, by the deeply penetrating and severely lacerated wounds, especially those of the extremities associated with fracture, vascular injury and muscle damage were prone to be the seat of gas gangrene. Such wounds filled with blood clots, often containing missiles, particles of clothing and bone fragments and a varied flora of germs, offered every condition for the rapid and successful growth of the organisms. In civil practice the same type of wound is often encountered, the result of explosive accident, gun-shot wound or industrial injury and crushing injuries sustained in various ways. Other methods of inoculation are: compound fracture, hyperdermic injection, post-operative wounds, pin pricks, traumatic rupture of some parts of the intestinal tract, and in association with other bacteria in both mild and severe cases of puerperal endometritis.

#### Accessory Causes.

The experience of the war observers has clearly demonstrated that a defective blood supply is probably the greatest single accessory cause for the organisms gaining foothold in the body once they have secured access to the wound. An impairment of blood supply may be affected in many ways. Careful investigation by certain observers has demonstrated that the circulation within muscle tissue is largely terminal and there is little anastomosis between larger trunks; also that certain muscles have only one artery of supply while others have two or more, hence initial death of the tissue may be produced by the trauma directly or by thrombosis or severance of the vessel or vessels of supply. Other factors to be considered are the constriction of the part by tourniquets, poorly applied dressings and bandages, packing introduced into the wound, and dressings that have become hard and dry from need of change. Severe shock

with its accompanying low blood-pressure also is a factor, and in the primary debridement of the wound, the blood supply of the remaining muscles may inadvertently be damaged by the surgeon.

#### Types.

The literature of the war period is rich on this subject. Many writers have described various forms of gas gangrene. However, for practical purposes it seems best to consider gas bacillus infection as a clinical entity of multiple origin and one in which the most striking signs and symptoms are not always the same in all cases. The thorough work of K. Taylor (8) seems to demonstrate that the infection passes through five stages if allowed to proceed unmolested. **FIRST:** is the dormant stage of localized wound infection; **SECOND:** the stage of gaseous distention, the result of obstruction to the escape of gas generated locally in the wound; **THIRD:** the explosive stage characterized by rapid extension of the swelling associated with subcutaneous crepitation; **FOURTH:** stage of septicemic intoxication; **FIFTH:** stage of general septicemia. This fifth or terminal stage of blood invasion occurs practically at death.

When seen early in the first stage, the disease can usually be confined here, but according to this writer, if there is not free drainage of the gas the disease progresses rapidly into the second and third stages. If however, prompt and adequate surgical treatment is instituted at this point, and too a large mass of muscles has not been destroyed, recovering usually takes place. If not, patient dies in a short time usually without reaching the final stage of septicemia. This writer probably over-estimated the mechanical importance of the gas in the spread of the disease.

Emrys-Roberts and Crowell (9) recognized three main types of the disease. The first and usual type represented by that seen in wounds of 12 to 24 hours of duration, or which developed a few hours after the primary debridement. Then there is (2) the very acute and fulminating type, where patient if untreated may be dead in a few

hours. The third type was a slow onset and became established only after days and even weeks from date of the wound. Indeed there are many instances of slumbering, latent infection that developed only after considerable time and elapsed; one as late as six (6) months after injury, and as the result of simple fracture months after the primary wound had healed.

#### Diagnosis.

In establishing cases the clinical pictures usually leave no doubt as to the diagnosis. There is no single early pathognomonic sign or symptom, the diagnosis generally depends on the combined presence of several factors, the character of the wound, swelling, crepitation, color of skin, odor and ability to press gas bubbles from the wound together with a thin discharge, are most reliable. The chief complaint of the patient is variable and pain is not always present. Pain followed by numbness is often an early symptom. Early diagnosis is important and by careful attention to the local physical signs as enumerated above, the diagnosis can often be made before general symptoms have had time to develop. There are two types of wounds in which gas gangrene is especially liable to develop. FIRST: the deep penetrating wounds with or without fracture and with or without severance of the main vessel of supply; SECOND: extensive surface wounds where gross laceration of muscle has been produced and large amount of infectious material has been carried in.

Culture is not of great value, although growth can usually be identified within 8 to 24 hours by culture on milk, but the gangrene may spread rapidly within that time. A negative culture is of no value and frequently cultures from rapidly spreading gangrene are sterile, and surgeons in the recent war often found positive cultures from wounds wide open and in need of no surgical attention. Indeed some considered the presence of Welch Bacilli in small numbers no contra-indications to suturing the wound. They came to regard the presence of large number of Welch Bacilli as good evidence of an active gas infection, while

their complete absence was not conclusive evidence of lack of infection. Many wounds would give positive culture for as long as 8 days without infection, and lasted much longer in those in which active gas occurred. The Streptococcus was frequently an accompanying organism. The Roentgen ray will show shadow casts by gas and can be used as a diagnostic aid.

#### Treatment.

The possibility of gas infection should be borne in mind in the treatment of all wounds in which muscle tissues have been extensively involved. The importance of preserving adequate blood supply, the avoidance of prolonged use of the tourniquet, the thorough excision of all lacerated tissue, with care not to leave any foreign bodies, the frequent change of dressings together with careful splinting of affected limb, and treatment to combat shock, are all factors of great prophylactic importance. Once the disease is established, treatment must consist of radical operation as early as possible. Timorous incisions are fatal and the affected tissues should be laid open by bold incisions in the long axis of the limb, and damaged muscle should be removed by cutting along normal planes of cleavage without opening into uninvolved muscles or fascial reflection. This excision should be carried to the point where muscle of normal appearance and reaction and of certain blood supply is assured. If it is a limb that is involved, the incision should be carried from above downward, so as not to interfere with a blood supply in the late stages of the operation, that was left in the beginning. The use of a constricting band is not permissible if it can possibly be avoided, as the cutting off of blood for a short time only, often leads to extension of the gangrene. If the main blood supply has been extensively damaged, or if muscle excision will lead to a limb functionally useless, amputation is best, and should never be delayed too long if gangrene is extending rapidly.

Muscle excision may be made by blunt or sharp dissection or with the actual cautery. Speed of operation is to be desired. The



wound should be left wide open, flooded with Dakin's solution, dressed frequently and cleaned thoroughly at each dressing. Other solutions have been used with success. Nacciarone (10) who had an extensive war experience used copious irrigation for 10 to 20 minutes at frequent intervals of an idion solution of his own formula. The experiments of Taylor and Austin (11) proved the detoxicating action of both Dakin's and Chloromine T. Solutions, and clinical experience has proved it to be the best post operative local accessory when properly used.

Wright & Flemming (12) demonstrated that the organisms of gas gangrene grow more favorable under conditions which reduce the blood alkalinity. The factor of acidosis, therefore, may give concern. They used the intravenous injection of 5% soda Bicarbonate in 50 c.c. doses together with oral administration of alkali in the form of lactate of soda in large doses, with apparent benefit.

Since this group of organisms is generally considered to be toxin producing, the use of serum as a detoxicating agent should be of value, and when it can be had, should be used. The experience of those who had war service differ as to its efficacy. In civil practice it is often impossible to get the serum in time for it to be of determining value. The treatment of gas gangrene by serum alone is certainly worthless.

#### Summary.

(1) The frequency of gas bacillus infection should be kept in mind.

(2) Careful, thorough and thoughtful debridement of all wounds of such nature as to permit of gas infection.

(3) Attack the condition early and vigorously once it develops.

(4) Amputation is often necessary but often may be avoided by wide excision of affected muscles and by keeping the resulting large open wound clean.

(5) Don't postpone amputation in rapidly advancing gangrene of extremity particularly if the main artery of supply is damaged or if mutilation will result in useless limb.

## PELVIC INFECTION IN THE FEMALE\*

### Review of the Subject

William H. Myers, M. D.,

Savannah, Ga.

In presenting the subject of Pelvic Infection in the Female, I do so realizing that it has been written about and discussed, within the last forty years, as have few other topics in medicine. However time-worn, there is probably no preventable disease which has suffered from such a diversity of opinions as has this one. Too, the results of treatment are far from satisfactory. Davis (1) said recently, that in the last decade there had been little, if any, decrease in the death rate from puerperal infection. It is estimated by different authorities, (2) that from fifty per cent to seventy-five per cent of female invalidism is due to pelvic infection. And Doederlein (3) says that ninety per cent of all cases of female invalidism and morbidity, not speaking of fatal cases of puerperal sepsis, are due to preventable causes. It is certain that pelvic infection from other causes has not been reduced recently, and it is probable that it has actually increased within the last few years, during which time moral laxity has produced much venereal infection, not to mention an increase in abortions, with their quota of infections. In view of these facts, it must be admitted that there is still much work to be done in conserving and treating this great class of sufferers, in whose interest I ask your forbearance.

Pelvic inflammation was first described by Sir Lawson Tait, of Birmingham. In 1877 he published a series of papers recording his observation on etiology, pathology, and treatment of ascending infection of the uterus and adnexa. For many years following these revolutionary teachings, a bitter controversy was waged, in which he was subjected to most severe criticism and abuse. In England, and on the continent, as well as in America, the medical profession was divided into those rallying to the teachings of Mr. Tait, and those fiercely opposing

\*Read before the Augusta (1924) meeting of the Medical Association of Ga.

them. As time went on, it was demonstrated conclusively that his teachings were correct, and that the infection was an ascending one, and that cellulitis, parametritis and perimetritis were, with rare exceptions, secondary to infection elsewhere in the genital tract. It was also conclusively shown that such conditions were susceptible to radical surgical relief. In this country, the late Joseph Price, of Philadelphia, was the leader in the battle waged, and it was through him that pelvic surgery was placed on a sound basis in America. Brown, (4) of St. Louis, says that a review of the literature of the last thirty years will show that the pendulum has frequently swung from extreme radicalism to ridiculous conservatism. All must admit that in the early days of this work, tubes and ovaries, which are so essential to the health of women, were sacrificed by the thousands. This however, was in no way due to the teachings of Tait.

Doederlein says the whole subject of pelvic infection may be classified into two types, ascending, or infection through natural channels, or descending, or through blood streams or continuity. This author says that generally speaking, bacteriology is of little value as to the course of treatment in pelvic infections, because there is no uniformity in the behavior of the invading organism. The streptococcus may be highly or mildly pathogenic. Hemolysis is not an inherent attribute of the streptococcus, but is acquired and may be lost. Saprophytes, including bacillus coli, may attain fatal virulence. There may also be an important factor lying in the anaphylaxis of certain patients toward infection. He says that the vast majority of infections are of the ascending type, and due to gonococcus or puerperal.

The causes of pelvic inflammation are gonorrhoea, confinement, abortion, curettage, and occasionally traumatism. The infecting organisms are the gonococcus, pyogenic, (streptococcus, and staphylococcus) tubercular, and others of less importance. Andrews (5) gives the order of frequency and percentage as follows: Gonococcus 43 per cent; Pyogenic 24 per cent; Colon 5 per

cent; Pneumococcus 4 per cent. Menge (6) reporting on results from tubal pus of one hundred and six cases, gives figures as follows: Sterile 68, Gonococcus 22, Tubercular Bacillus 9, Streptococcus 4, Staphylococcus 1, Anaerobes 2. Hyde (7) in the examination of 2973 cases, not including tubercular, found tubal contents sterile in 1998; Gonococcal 579; other and mixed infections 458. Noeggerath and Wertheim (8) examined 312 cases and found: Sterile 122; Gonococcus 65; Streptococcus 11; Staphylococcus 6. Gurthrie (9) collected data from 15 Iowa surgeons, and found 70 per cent of all their cases were gonorrheal. Crossen (10) lays great stress on the importance of differentiating the pyogenic from the gonococcus infections. He points out that a large proportion of the former follow childbirth or abortion, while the latter give a history of irritability of the bladder and leukorrhoea appearing shortly after marriage, or a suspicion cohabitation, together with evidence of external genital infection, while the tubercular bacillus is secondary to tuberculosis in other parts, and not rarely is found in virgins. I believe it is important to determine, if possible, the character of the infecting organism. A study of the presence of the organism in the Fallopian tubes shows that gonococcal pus usually becomes sterile in from two to four months. Neisser (11) studied 143 cases of gonorrhoeal pelvic infection which had been latent for periods of from two months to eight years, and in only eight cases did he find the organism. On the other hand pyogenic organisms may become encapsulated and remain dormant, but virulent for long periods. Miller (12) reported one case where streptococcus existed six years, and another for a period of twelve years. While Martin (13) mentions one case where streptococci were present nineteen years after infection. If the infecting micro-organism could always be accurately determined, the treatment would be very much simplified.

The atria of invasion are, the perineum, vagina, cervix, uterine surface tubes and peritoneum. Infection having occurred in any of these locations, advances by lymph

spaces and vessels, by veins as in thrombophlebitis, and continuity of tissues. Cullen (14) says that puerperal infection is wound infection, which may be a small tear in the perineum cervix, any abrasion in the vagina, a large wound of the placental site, or a wound caused by finger nail, curette, sound, or other instrument. It is remarkable that infection does not occur more often, for this region is most difficult to render surgically clean. This is particularly true when we consider the many vaginal examinations made, and often made without regard to asepsis. But Nature has mobilized her forces for resistance in the zone of the parturient canal, and according to Armitage, (15) has prepared the field by conferring infiltration and oedema. Cellular tissues surrounding lacerations of the perineum and vagina are rarely involved. The cervix, however, is different as it is more richly supplied with lymphatics than any other portion of the genital tract, and readily admits infection to the cellular tissue of the broad ligaments. If the infecting organism is streptococcus, it not only passes by lymph channels, but passes right through lymph glands into the general circulation, and the patient dies from infection of the cellular tissue of the broad ligament, and subperitoneal tissue behind and in front of the peritoneum, but without entering the peritoneal cavity. When the staphylococcus is the infecting organism, the pathology is entirely different, since it passes through the lymph spaces slowly, and is often arrested, and circumscribed abscesses formed in the broad ligament or in the cellular tissue beneath the peritoneum. When the infection is gonococcal there is rarely any involvement of the cellular tissue of the broad ligament, or any where else. The organism invades by continuity of tissue, and when it reaches the internal os, it is said by some authorities that it alone, is able to traverse the "fighting zone," in the uterine cavity, where it is found in pure culture. It passes out into the tubes, producing as it advances, an inflammatory process involving the tube, but not the surrounding tissues. In due course of time the isthmus is occluded by

adhesions and oedema, and the ostium abdominale is reached, where leakage may take place periodically, but this opening too, becomes closed early. The tube becomes filled with pus, until it presents a sausage shaped appearance, sags into the cul-de-sac, and attacks its fimbriae to some contiguous organ, which serves to more effectually seal the opening.

The symptomatology of pelvic infection varies according to the invading organism, and the atrium of infection. This phase of the subject is entirely academical and will receive only passing notice, with no reference to detail. But the usual course of puerperal infection is for the patient to have a chill on the second day, followed by a temperature of 104-106, with subsequent chills, exquisite sensitiveness in the lower part of the abdomen, with a board like rigidity of the over lying muscles. Vaginal examination reveals a fixed tender uterus, which is boggy and enlarged. Thrombosis occurs most often when there is a lacerated perineum, followed by cellulitis of the broad ligament. It is for this reason that thrombophlebitis is rare in abortion, but more frequent in the puerperal state. Armitage (15) says that if the placental site is infected thrombophlebitis of a different character follows. It runs a low fever of from 99½ to 100½, and in from five to fifteen days after delivery, and when all is thought to be well, the thrombus becomes dislodged. If the thrombus enters the general circulation the same premonitory symptoms are present as are seen in post-operative thrombosis. The onset is ushered in suddenly by pain over the heart, kidney or liver. The heart races, and a little blood may be seen in the urine. The pelvic organs are not usually painful, because thrombosis of the veins of the placental base is not painful. The patient dies in the first or subsequent attack in eighty-five per cent of the cases.

The treatment for pelvic infection should be directed along two lines, the prophylactic and the active. The obvious thing to do is to prevent extension of infection by ade-



quate treatment of all acute gonorrhoeal infections, by more careful obstetrical technique, and education of women as to the dangers of self induced abortions. And lastly education of the medical profession in abstinence in the use of the curette, except in rare instances. In 1916, Dr. Thomas J. Watkins (16) of Chicago, read a paper on pelvic infections, in which he advised most strongly against the use of the curette. He says that the curette should never be used in an septic uterus. That if the uterus has anything in it, that it will be expelled, ordinarily, but that if it is not expelled, that it is a dangerous matter to attempt any manipulation on account of embolic extensions from dislodgment of the septic thrombi, from the uterine sinuses. In the discussion of Watkins paper, Davis of Philadelphia; Cullen of Baltimore; Carstens, of Detroit; Barrett of Chicago, and Deaver of Philadelphia, all agree with Watkins upon the use of the curette.

Treatment of pelvic infection has been a storm center of discussion for many years. There are those who favor a very radical course of treatment, among whom are Price, Kennedy and Dubose. But the great majority favor a conservative course. In this group are such men as Doederlein, Clark, Norris, Grad, Cullen, Novak, Watkins, Andrews, Elting, Donhouser, and others.

The preliminary treatment advocated by most of these authorities include strict rest in bed, ice cap to the abdomen continuously, with hot douches or hot air treatment. Schindler and Drenkhahn (17) advocate the use of atropine, in gonorrhoeal and puerperal sepsis, with the idea of causing a limitation of involuntary uterine movements. They reason that the gonococcus is a non-motile organism, but that it advances through active movements of the uterus, and that they believe that atropine paralyzes these automatic movements, and prevents the advancement of infection. The use of purgatives should be abolished in the acute stage of pelvic infection, and the bowels should be made to function by the use of enemata.

Clark and Norris (18) say that the results of palliative treatment are often most satisfactory. Large painful tubes resolve themselves into small adherent organs. The ovarian condition subsides and tender adherent masses disappear. By this treatment a certain percentage of cases can be spared any operation whatever. Prochowicz (19) in treating 160 patients between 1892 and 1905, claims to have cured fifty-five per cent of them by the expectant method.

In the acute stage surgery should not be resorted to, except for the purpose of draining an abscess. If the abscess is in the cul-de-sac, an opening should be made near the cervix in the posterior fornix, and the abscess cavity gently opened. Any attempt at irrigation should not be made for the reason that it very often proves fatal by breaking down the wall of adhesions and flooding the abdominal cavity with pus, which results in general peritonitis and death. Cullen reports one fatal, and one near fatal case following irrigation. The self retaining T drainage tube is inserted, and the discharge allowed to drain through this tube out through the vagina. He advocates the drainage of abscesses in the broad ligaments by an McBurney incision, down to the perineum, but not through it. He then separates the peritoneum from the abdominal wall down to the broad ligament, which is opened and the pus cleared out and drainage inserted. Polak, (20) in his study of five hundred cases of pelvic infection, laid down the following rule for determining the time for performing laparotomy. He said, "No infection should be operated upon until it is possible to examine the patient without finding an exudate or until such examination fails to excite a temperature exacerbation, or an increase in the leukocyte count, or until the said count is below, and remains below 11,000." In operating upon these cases, it must be determined what organs shall be conserved, and what shall be removed. Experience with the gonorrhoeal infection has shown that it produces almost certain sterility, and that

the tubes would be of no value if left in, in even though they showed no gross pathology. Every effort should be made to conserve both ovaries, if such can be safely done, as a young woman who has suffered the loss of her ovaries, enters upon a life of invalidism in which she spends her time vainly seeking relief. In gonorrhoeal abscesses of the ovary, no effort at conservatism should be made, as it has been proven many times that nothing but radical measures will suffice. In pyogenic infection a different course should be followed, as sterility does not follow these infections as often as it does in gonorrhoeal, and more conservatism can be practiced. When it is necessary to sacrifice both ovaries, then the uterus too, should be removed, as it will only serve as an useless organ, and may be the seat of malignancy, and otherwise cause trouble. It should be remembered that any operation upon the ovaries will usually change the character of menstruation, producing excessive or diminished menstruation, as well as other irregularities.

The history of draining of the peritoneal cavity dates back to the time of Celsus, who described the drainage of that cavity by means of lead and brass tubes. In the fifteenth century we read that these were still used by Jerome of Brunswick, both for the peritoneum and for deep wounds. In the sixteenth century Ambrose Pare, Guillemeau, and others used drainage tubes which, according to Godlee, were similar in many respects to those of modern times. In the seventeenth century we find Scultetus and others, who were most enthusiastic in draining wounds.

Some surgeons, like Cullen, drain through the vagina, and close the abdominal wound completely. But breaking down of the line of sutures is very common, with the result that ventral hernia follows. Others have found hernia far less common, and results just as good by putting drains through the lower end of the abdominal incision. Still others use combined drains through the abdominal incision, and through the vagina. Cullen says that pelvic drainage is often a very simple procedure, but now and then

somewhat difficult. He advocates an excellent method of pelvic drainage when there is capillary oozing from the pelvic floor, or where owing to the nature of the case there is danger of infection, and where a pelvic drain is a great comfort to the surgeon. With the patient in the Trendelenburg position and with the pelvis carefully walled-off, an assistant wipes out the vagina and with a pair of long Kelly forceps presses the posterior vaginal wall up into the pelvis until the elevation on the pelvic floor resembles the peak of a small tent. The operator then cuts down upon the forceps from above. As soon as the tip of the forceps come through into the pelvis the vaginal opening is made wider either by spreading the forceps from below or by introducing a uterine dilator from above. A large tablespoon held against the posterior surface of the pelvic wall acts as an excellent shield or protector for the rectum, while the vaginal forceps grasp the cigarette drain and draw it as far into the vagina as the operator deems wise. The surgeon now fits the free gauze ends into the pelvis, cutting off any excess that may be necessary and so places the drain that, if possible, the gauze does not come in contact with any small bowel. He warns against taking the drain out before the fourth or fifth day, as the intestines are still adhered to the drain, and may be pulled out with the drain, and produce fatal results. He also warns against careless introduction of the forceps into the vagina. He said that in one instance the assistant caused the bladder to be cut, through the introduction of the forceps in the urethral. In another instance the rectum was opened through a similar mistake.

No originality is claimed for the material contained herein, but this subject is reviewed and presented to you with the hope that the facts contained will refresh your memories on this subject.

- 
- (1) Dr. Davis, quoted by Doederlein. *Surg. Gynec. & Obst.* 1920, XXX 599-603
  - (2) F. G. Dubose, *Surg. Gynec. & Obst.* 1921, XXXIII 299-307.

- (3) Theodore J. Doederein  
Surg. Gynec. & Obst. Same as (1).
- (4) John Young Brown  
J. Am. M. Asso. LXXI 423-424
- (5) Andrews—Quoted by Norris & Clark.  
Surg. Gynec. & Obst. 1901, XI 398-413.
- (6) Menge—Same as (5)
- (7) Hyde—Same as (5)
- (8) Noegerath and Wertheim—Same as (5)
- (9) Gurthrie—Same as (5)
- (10) Crossen—Same as (5)
- (11) Neisser—Same as (5)
- (12) Miller—Same as (5)
- (13) Martin—Same as (5)
- (14) Thomas S. Cullen.  
Surg. Gynec. & Obst. 1917, XXV 134-146.
- (15) H. M. Armitage.  
N. Y. Med. Journal. Oct. 14, 1916.
- (16) Thos. J. Watkins.  
J. Am. M. Asso. 1916. Vol. 77 LXV 211  
1076-1079
- (17) Schindler and Drenkham—Same as (5)
- (18) Clark and Norris.  
Surg. Gynec. & Obst. 1910. XI 398-413
- (19) Prochownick—Same as (5)
- (20) J. O. Polak  
N. Y. Med. Journal 1916. XVI 344.

### Discussion on Paper of Dr. W. H. Myers

DR. MARION T. BENSON, Atlanta. I wish to thank Dr. Myers for this important paper. In dealing with the future generation I think this is the most important subject we have. The object in teaching pelvic infection is to prevent pelvic infection. The great majority of these infections can be eliminated. Infections following delivery and following abortion should be unknown. If we take the proper precautions in our deliveries and abortions we should not have pelvic infection from these two sources.

In regard to the curet and so forth in abortion, there are two lines of treatment. I think it is a mistake to leave the debris in the uterus following abortion. Some think it a serious mistake to enter the uterus following abortion, as those cases will have a temperature and foul discharge and the infection is being constantly taken up. I have never seen any harm in taking sponge forceps and removing this debris. The next day the temperature usually is normal and the patient practically well. Why should it be left in for several weeks with the patient absorbing toxin all the time.

In delivery we should be as near sterile as possible and our technic should be improved in that line. The placenta should be inspected carefully after delivery to see that none has been left in the uterus. If we do this our infections will be cut down to almost nil.

DR. B. H. WAGNON, Atlanta: Since our time is limited I will not go back further than Lawson Tait but, as Dr. Myers said, since his time we have had discussions in reference to the treatment of pelvic infection. In this we have to distinguish between pelvic inflammation and puerperal septicemia. Septicemia requires very little surgical interference. On the other hand,

the largest per cent of pelvic inflammations, which is above 70 per cent, are caused by gonorrheal infection. Time does not permit us to discuss the means by which the tubes and ovaries and parametrium become infected, and the way the gonococci ascend, but we know that by removing a gonorrheal pus tube, which is always a mixed infection, we accomplish a good deal. If we get a pure gonorrheal infection in a tube that tube after a while will become a hydrosalpinx and lie quiescent, not giving much trouble, but these pus tubes in 90 per cent of the cases showed mixed infection.

The Doctor spoke of sterile pus. That can occur in nearly every case and pure culture of gonococci form afterward in these types. You try to grow it on agar and you can nearly always demonstrate this infection.

I maintain that if these pus tubes are operated on early we can conserve more tissue, and that it is conservatism to operate just as soon as we can palpate a tumor in the pelvis.

DR. H. H. McGEE\*, Savannah: It occurs to me that the most essential thing this Association should think of in regard to this paper is the possibility of preventing abortions. In the State of Georgia it is an unusual thing for an abortionist to be punished. There are always good lawyers who can be secured for a certain amount of money to protect these people. It is a fact that many women who have no right to have babies become pregnant and have them. It is a source of income to unscrupulous people among the profession, for nurses and midwives, to produce abortion. It is a blot on civilization that women are made invalids in the numbers they are by criminal abortions. It would be fitting for this Association, individually if not collectively, to try to create a better public opinion in their several communities against the frequency of abortion. In Savannah we know the men who do the curettages, they do them frequently. We know the man who is considered by every man in town as an abortionist, and yet we cannot convict him. If he is convicted he does not serve his time. I agree with the gentleman who preceded me that it is in order to remove the debris left from an abortion with a sponge or a spoon. That is good common sense for it allows drainage and puts the patient in better condition.

DR. E. A. WILCOX, Augusta: I agree that the most important thing is to determine whether it is septic infection following

\*Deceased.



abortion or labor or instrumentation, or whether it is gonorrheal infection. I think we are all agreed that the thing to do with puerperal infection is to wait, but this conservatism must be very carefully carried out. The patient should reach a point where they are stabilized or show a tendency to deteriorate, and when that point is reached it is time to intervene.

As to pure gonococcus infection of the tubes, I think we are all agreed in that point that it is wise to wait until the inflammation has abated. A pure gonococcus infection, which is an initial infection, will probably become sterile in the tube within ten days. At least, research carried out on the bacteriology of the tubes has shown that to be the case. The great majority of these tube infections, as has been said, are mixed infections, and if we have waited ten days and the temperature has persisted that means that a mixed infection is present. We are all familiar with the early closure of the ostium abdominale, but the uterine end remains open to a great extent.

I believe that the tube infection occurs principally at the menstrual period for almost every exacerbation will be dated from that time. I think it is far safer to make a culture in all cases and drain in doubtful cases. This will take care of the serum and pus, and if the culture after 24 hours shows streptococcus or other organisms, the drain can be left in as long as necessary. If the culture is sterile the drain can be removed in twenty-four to forty-eight hours.

DR. C. H. RICHARDSON, Jr., Macon: I wish to discuss the treatment of pelvic infection. In the first place, in the acute stage following gonococcus infection, I think we are all agreed that absolute rest, with the ice bag, and waiting for the infection to subside, is the better policy, without attempting to do any operating.

In the treatment of puerperal infection, when established, the patient should be placed in the Fowler position and all intrauterine meddling should be omitted. The patient's general resistance should be built up. I think we should take cognizance of some work that is being done at present in these hopeless cases of bacteremia with patients that are going to die. Some work is being done with the intravenous injection of mercurochrome and the results seem to be promising.

DR. W. H. MYERS, Savannah, (closing): Since the preparation of my paper some work has been done by investigators, in Chicago, who have reported on one thousand cases of abortion in which the conserving method has been carried out. They took

the cases that came in, and only those with distressing hemorrhage or something of that nature, were subjected to operation. The patient is kept in the hospital for five days if without fever, and if fever is present they do no operation for ten days. They report excellent results. For economic reasons I do not think we, in this section, can adhere to the strict policy of conservatism, for we cannot keep these patients in the hospital for prolonged periods, but must let them go home and keep up the treatment there. Most of our people have to work and attend to their families and home, and cannot afford to have a prolonged period of invalidism. The thing we must do is to take care of them quickly, and restore them to their homes. We sometimes sacrifice organs that are of benefit, but we get them to work sooner.

Regarding Dr. Richardson's views, I think they exactly hit the nail on the head. The policy he advocates will give most excellent results.

#### EXTRACTS FROM INAUGURAL ADDRESS\*

Theodore Toepel, M. D., President,  
Fulton County Medical Society,  
Atlanta, Ga.

Public opinion is today perhaps more critical of us than at any time in the past. Our work is being scrutinized and we are held answerable in many directions. That the public is not altogether satisfied with our performances is in some measure shown by the great increase in numbers which the cults have obtained and the legal status given to them by our Legislature. The great outstanding problem before us today is that involved in the delivery of adequate, scientific, medical service to all the people, rich and poor, at a cost that can be reasonably met by them in their respective stations in life.

The part of the physician in the community is manifold; he is expected to right wrongs and relieve ills. Not only do immediate injuries and maladies command his attention but his duties are conceived in a far broader spirit. Modern medicine takes into account the possibilities of preventive as well as corrective measures. It aims to prolong life and to conserve vitality and human existence thereby should become more pleasant and efficient.

\*Read before the Fulton County Medical Society, January 8, 1925.

The broad-minded physician has been described as one who conserves the money as well as the health of his patients. In a sense, he is a trustee both of their bodily welfare and of their finances. In other words, a physician is not justified in prevailing on sick people to go to a great expense for diagnostic tests or therapeutic procedures which are of theoretical interest; rather must he advise those measures which are as safe and certain as possible and which offer the prospect, through relieved symptoms, of a good return for the financial investment involved.

**Membership:** Our society is growing in importance and we now have a large enough membership to maintain it under the present plan of organization. Membership in the society is the best evidence of professional standing. It is regarded by the public as a guarantee of efficiency and reliability. In order to continue to merit this public trust the time has come to scrutinize more carefully all applications for membership and to reject candidates whose records are not without fault.

**Clinical Talks and Papers:** The clinical talks and papers presented at the meetings of the society should be interesting, original and well prepared, because the greater number of the physicians are members of staffs of hospitals where much routine work has to be done and only through superior programs can we hope to continue the present high percentage of attendance.

**Fifth District Meetings:** The innovation recently introduced by your board of trustees, to hold the next meeting of the Fifth District at one of our regular meeting nights might be extended, so that twice a year our friends from the adjoining counties, members of the 5th District Medical Society, might furnish and conduct the program.

**Committees:** If it meets with the approval of this body I would like to see the chairman of each of the standing committees meet with the Board of Trustees and participate in the deliberations for the good of the society. A committee, selected with care, with a strong chairman at the head will discover in studying the purpose of its existence that

there is much to do which is of direct benefit to the society.

**Committee on Public Policy and Legislation:** This committee should secure and enforce legislation in the interest of public health and scientific medicine in the county of Fulton. It should keep in touch with the tendencies of progressive medicine and public opinion and endeavor to shape legislation so as to secure the best results for the whole people.

The committee should meet regularly at least once a month, plan its work, such as familiarizing itself with the present status of sanitary, health and hospital conditions in the city and county; seek advisory affiliation with the different committees in charge of these affairs. It should study our present Medical Practice Act and in conjunction with the State Committee on Public Policy Legislation, or independently, recommend to the next meeting of the House of Delegates, which meets in Atlanta the second week in May, that the fundamental education requirements and the knowledge of anatomy, physiology, pathology and chemistry be the same in all candidates who would practice the healing art in the State of Georgia. This committee should make regular reports to the society through the Board of Trustees.

**Public Health Committee:** The public health committee has mostly been an honorary grouping of members. It is far from me to honor the appointed gentlemen in such a way. This committee should stimulate the enforcement of sanitary and medical laws of the city and county; to promote city and county public health organizations and to co-operate with them; to assist the Publicity Committee to educate the public through the lay press in matters of health, hygiene and sanitation and the real meaning of modern medicine; to provide public speakers and articles to this end and to work for proper health subjects to be included in the curriculum of our public schools. This committee should meet regularly at least once a month, map out its plan of work and the chairman should make regular reports to the society through the Board of Trustees.

**Publicity Committee:** I consider the Publicity Committee one of the most important committees we have. The time has come when some of our ancient rituals that have stood between us and the laity should be discarded. We must forever abolish the chasm that has existed between the doctors and the laymen. While it may lessen the layman's awe for the medical profession it will greatly increase his interest in medical subjects and make him understand our aims and become more co-operative. If we step down a little from our pedestal, we shall surely come to a better understanding with the laity.

The Publicity Committee should furnish the lay press with articles on preventive medicine and news items of the scientific proceedings of our meetings during health week. Such items in connection with papers and discussions would be of greater value to the Fulton County Medical Society and the individual member than if he has to resort to the society column for a little personal publicity.

I consider this committee of sufficient importance, that it should have weekly conferences, and the work should be so divided that each member be made responsible for a certain phase of it. The chairman should make regular reports to the society through the Board of Trustees.

**Women's Auxiliary:** The Women's Auxiliary, which has been recently formed, is a valuable acquisition in bringing into closer union the bond of fraternity among the doctors and their wives. In the course of time it will serve as a splendid medium in spreading medical facts in fields which doctors themselves do not reach.

**Mutual Protection:** I wish to call your attention to the need of better protection against the professional dead beat, who takes advantage of the physicians' lack of business organization.

The pediatricians of our society have among themselves formed a mutual protective organization, which to all appearances

gives them the protection to which they are entitled.

Far be it from me to place the profession of medicine on a level with strictly commercial concerns. There is not a member in our society who is not affiliated with one or more institutions where people unable to pay may get his services gratuitously and where it is given cheerfully. But it would be to our credit and pecuniary benefit if our membership would organize itself into a mutual protective organization for the purpose of raising our standard of commercial unity and discourage as much as possible and ultimately eliminate entirely the professional dead beat.

No member, regardless of what his financial protection may be in the shape of collection agencies or private legal talent, can know every citizen and his intentions. It is only by a composite, strong organization to which every member of our society should belong, that for an additional small annual fee we would keep ourselves informed as to the financial status of new patients who seek our services. If you wish it I will appoint a committee of five, representing all branches of medicine, who will thoroughly investigate this proposition and make recommendations to the Board of Trustees and finally to the society.

In conclusion let me request of you to make our home the center of all activities in which a medical society is interested. In a membership of approximately 400 there is necessarily a divergence of interest, but our home is large enough to concentrate here all social, literary and scientific activities.

With your co-operation it shall be my effort to make this administration a truly democratic one and by the united effort of the Board of Trustees, the committees and all members our society will gain in influence and its aims and purposes become better known.



**SOME GEORGIA DOCTORS**

**B. H. Wagnon, M. D.,**  
**Atlanta, Ga.**

We, as Georgians, and readers of this Journal, should be justly proud of our pioneers in medicine and surgery. No state that I know of can boast of such an array of men that are responsible for the foundation of true medical science as Georgia.

These men in many instances were too modest to record their observations and but for the loyalty of their friends their work would have been unnoticed, as they did not write upon or report their discoveries and work in early medicine and surgery.

It would not be amiss to call attention briefly to some of these men here, although, their biographies and histories can be found in the literature in our State library.

Dr. Milton Anthony, born 1789, died 1839, founded the first Medical College in Georgia in 1828. He resected the 5th and 6th rib with a portion of gangrenous lung in 1821, the first operation of this kind reported in medical literature. In 1828, he demonstrated and treated five cases of fracture of the femur by extension with pulleys and weights after it had been suggested to him by Dr. W. C. Daniel, of Savannah, Ga. He founded the first Medical Society in Georgia in 1822. He was one of a group of doctors who applied to the legislature of Georgia requesting the creation of a board of medical examiners. He was an authority on yellow fever from which he died in 1839.

Dr. Richard Banks, for whom Banks County, Ga., is named, was born in 1784. Unlike Dr. Anthony, he was either too modest or disinclined to report his observations. He was first to do harelip operation; he was first to remove the parotid gland, to do this, he disarticulated the lower jaw so as to get to the gland; he was among the first to do an operation for cataract, of which he did a great many successful ones. One of his first and most successful operations was for removal of stone from bladder which he did no less than 64 times prior to 1832.

We must not forget the fact that these men were accomplishing these marvelous results without the benefit of general anesthesia for the use of sulphuric ether, as an anesthetic had not been discovered. Dr. Banks died in 1850, having never reported a case or allowed anyone else to do it for him.

Dr. Henry Fraser Campbell, born in Savannah, Ga., in 1824, measured by the standards of King David. He was truly a great and good man. He was the first and only Georgia doctor to be president of the American Medical Association; he was one of the founders of the American Gynecology Society. He was the most gifted and prolific writer of all our early pioneers in medicine and surgery. He discovered and wrote at length upon the excito-secretory system of nerves, in 1853, for which he was made a member of The Royal Medical Society of Sweden.

Dr. W. C. Daniel of Savannah, Ga., discovered and treated fractures of the thigh by extension with weights and pulleys. This was prior to 1824, he reported his cases in 1829 which was 21 years before Buck's extension apparatus was introduced in a New York Hospital. Dr. Daniel introduced our present day method of treating malaria.

The discovery of ether anesthesia by Dr. Crawford W. Long, of Jefferson, Ga., has been told by Dr. Long and others and is a well known fact in medical history.

Dr. Tomlinson Fort practiced medicine for nearly 50 years at Milledgeville, Ga., and in 1849 wrote a book on practice of medicine and dedicated it to the physicians of Georgia.

Dr. Paul F. Eve, of Augusta, Ga., introduced in America the bilateral operation for Lithotomy. Dr. Eve performed the first successful abdominal hysterectomy done in America in April, 1850. He also operated for and successfully removed a large fibroid polyp from the base of cranium of a negro boy in 1849.

If space in this Journal permits, brief notes on other famous surgeons of Georgia will follow in the next issue.

**THE JOURNAL**

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Profession of Georgia.

65 Forrest Ave., Atlanta, Ga.

APRIL, 1925

ALLEN H. BUNCE, M. D., Editor  
 M. C. PRUITT, M. D., Business Manager  
 Publication Committee  
 CHAS. USHER, M. D.  
 S. J. LEWIS, M. D.  
 T. C. THOMPSON, M. D.

Articles are accepted for publication on condition that they are contributed solely to this Journal.

Manuscripts should be typewritten, double-spaced, and the original (not the carbon copy) submitted. Used manuscript is not returned unless requested.

Communications and items of general interest to the profession are invited from all parts of the State. We especially invite county society secretaries to send us information of happenings in the county that would be of interest to the members throughout the State.

**Editorial Department****OFFICIAL CALL**

To the Officers, Fellows and Members of  
the American Medical Association:

The Seventy-sixth annual session of the American Medical Association will be held in Atlantic City, New Jersey, from Monday, May the twenty-fifth to Friday, May the twenty-ninth. Nineteen hundred and twenty-five.

The House of Delegates will convene on Monday, May the twenty-fifth.

The Scientific Assembly of the Association will open with the General Meeting held on Tuesday, May the twenty-sixth at 8:30 P. M.

The various sections of the Scientific Assembly will meet Wednesday, May the twenty-seventh at 9 A. M. and at 2 P. M., and subsequently according to their respective programs.

WILLIAM ALLEN PUSEY, President.

OLIN WEST, Secretary, Chicago, Ill.

**SCIENTIFIC ASSEMBLY**

The General Meeting, which constitutes the opening exercises of the Scientific Assembly of the Association, will be held Tuesday evening, May 26, 1925, at 8:30. The Sections will meet on Wednesday, Thursday and Friday, May 27, 28 and 29, 1925.

**Convening at 9:00 A. M. the Sections on**  
Practice of Medicine.

Obstetrics, Gynecology and Abdominal Surgery.

Laryngology, Otology and Rhinology.

Preventive and Industrial Medicine and Public Health.

Pathology and Physiology.

Stomatology.

Urology.

Orthopedic Surgery.

**Convening at 2:00 P. M. the Sections on**  
Surgery, General and Abdominal.

Ophthalmology.

Diseases of Children.

Pharmacology and Therapeutics.

Nervous and Mental Diseases.

Dermatology and Syphilology.

Gastro-Enterology and Proctology.

Miscellaneous Topics.

**Registration Department**

The Registration Department will be open from 8:30 a. m. until 5:30 p. m. on Monday, Tuesday, Wednesday and Thursday, May 25, 26, 27 and 28, and from 8:30 a. m. to 12:00 noon on Friday, May 29, 1925.

**THE GORGAS MEMORIAL INSTITUTE**

The Gorgas Memorial Institute seems to be accomplishing its initial purpose of uniting laymen and doctors, and instilling into the masses a recognition of the fact that scientific medicine is the only proper authority in health matters.

The Gorgas Memorial Institute evidences a healthy growth from the Atlantic to the Pacific. The value of periodic health examinations is a subject that the foundation is stressing in hundreds of newspaper articles, in public talks and in radio addresses, the country over.

Scores of editorials have been written and published by leading newspapers. Without exception they have deep sympathy with the ideals of the organization and heartily endorse it.

A special article written by the Detroit Saturday Night and appearing in the issue of February 14, is pertinent. It reads in part:

"Quacks and quackery in the field of medicine and general health protection will receive a heavy blow when the Gorgas Memorial Institute, recent-

ly founded in honor of the great army medical man who showed the world that yellow fever and other pestilences could be conquered by preventive methods, gets functioning.

"The Institute is not heralding as one of its purposes the counteracting of propaganda such as is spread by Bernard MacFadden and others of his kind who use every opportunity to attack the medical profession, but just so far as its plans, as announced, are successful, it will help to overcome pernicious teachings and ignorance regarding health."

The article goes on to say:

"The Institute will carry out General Gorgas' ideas of the exercise of preventive measures and the use of scientific medicine to check disease and wipe out pestilence. It is estimated that modern ideas of sanitation, coupled with the principle of periodic examinations such as General Gorgas practiced in the United States army during the world war, would mean a saving of \$1,500,000,000 annually. And the decrease in sickness and increase in happiness would be worth as much more."

"On any given day there are 3,000,000 people on the nation's sick list. One million of these are gainfully employed. The daily loss from this one source is staggering."

The County Societies are also proving receptive to the Gorgas Idea. They see in the movement a plan which will aid each member individually.

---

## GEORGIA DOCTORS AND MEDICAL LEGISLATION

---

### Shall we Accept the Challenge and Progress or Drift with the Tide of Indifference, to Our Own Discredit and the State's Economic Undoing?

---

There have been guardians of the liberties of American Institutions throughout the period of our history as an Independent Republic. The sacrifice of soldier's lives on the field of battle has been more dramatic but none the less real than the laying down of life by champions of the liberties and rights of our people in the fields of politics, religion, education and public health.

The sentiment underlying and permeating any movement which has, in the past, challenged the valor of American manhood, whether on far-flung battle fields when Old Glory was threatened or on tranquil western plains, the sunny stretches of our Southland, or the Metropolitan East, has been threatening clouds of harm to the rank and file of our people. Such a threat has long existed in the form of false methods of healing, posing under various names but possessing in common, unscientific and unproven theo-

ries with respect to the cause and nature of disease. Much of this evil in medicine has appeared in "sheep's clothing and under the pretext of new and effective methods of medical service to our people when established measures are said to have failed. Such deluded advocates have sought to summon to their aid public sentiment under the cry of persecution and unfair dealings in a free country. Disciples of Bolshevistic movements and notably the advocates of cults and spurious forms of practice of medicine, have always appealed to ignorance and prejudice. We cannot deny that progress has been made. These misguided devotees of questionable systems, have entrenched themselves by organized effort directed by astute politicians, by ample lobbying funds and by manipulations conducted behind closed doors, far from the knowledge of those whose duty it has been and WHOSE DUTY IT IS to guard the people's interest with respect to the progress of legitimate medicine. We are directly concerned with the protection of the rights of Georgia's Citizens.

The people of Georgia need more than anything else sound bodies and active minds. To paraphrase a sentiment of Dr. J. W. Simmons, of Brunswick, an ardent member of our Society, What profiteth it a man to ride smoothly over inviting Georgia boulevards, breathing invigorating ozone to the rhythmic music of a high-powered limousine, to be shaken to death at night by malaria chills, or having subsisted on the wholesome milk of registered cattle and the incomparable flavor of country-cured ham secured from blue-ribboned swine, to suffer the erstwhile ruddy cheek reduced to an ashen pallor by the insidious ravages of hook-worm diseases. Emphasis of State Government on the construction of good roads and on cattle and swine husbandry is to be encouraged, and we of the medical profession will lend the full weight of our influence in this direction, but is it not time to consider first the health of the Citizen of Georgia for whom all these things must be regarded as subservient? When our people are sick or threatened by epidemic or



disabled by accident or rendered inefficient by distortion of mind, no false prophet of new-found doctrines of health will be found adequate to meet the situation. Past emergencies of this nature and countless sufferers brought back by the tender and faithful administrations of the regular practitioner of medicine in Georgia, attest the efficiency of the old School. Then why the spread of nostrum and charlatan? Has it come up to meet a need in Georgia? Rather has it not grown out of plans to commercialize the misfortunes of the sick? Yes, you answer, but is it not also true that quacks and quackery have made progress because the doctors of Georgia have not measured up to their responsibilities as protectors of the physical welfare of our people? Have you, doctor, in the past concerned yourself with legislation in Georgia affecting your own rights and those of the people under your immediate care? Are you familiar with the statutes in the code of Georgia whereby charlatans are encouraged to come to Georgia as a profitable field for operation? Unless we, whose duty it is, respond to the urgent demands of our time for men who will challenge the right of those moved by unworthy motives in medicine, who shall lead the fight for measures that will safeguard our people, and what group of Georgians will offer to mould sentiment in our profession which will drive from amongst us those who would debase a holy calling by its prostitution to the ranks of a trade.

Argument is not needed. Eloquence is impotent. Plain words must be spoken. Indifference and lethargy has choked the noble sentiment of our members. We have lived too much unto ourselves and drawn our limiting horizon too closely about us. Doctors of Georgia, this appeal is for a re-dedication of time and talent to the defense of our profession and through it to the people of our State. We have the potential power to shape legislation in Georgia and the call is now made to you that we stand together for the preservation of the tenets of the most glorious profession on earth and for the translation of its benefits into an

intensified service to the people of our State. They are entitled to the best medical service scientific effort has produced. Shall we permit less?

Your Committee on Public Policy and Legislation is now engaged in working out plans whereby every member of our Association can have an active part in the fight to restore the dignity of the profession to which he has devoted his life. Let us awake and take our place in the new world in which we live. We cannot longer withhold our influence from the realm of politics. We, as an Association, must be felt in Georgia when legislators direct themselves to the task of making laws affecting the public health. Even more, we must initiate new laws and carry to an effective application those, such as the Ellis Health Law, which have already been placed on the statute books. Your Committee has faith in the members of this Association. It has not grown to its present commanding place among the State Associations of our beloved Country except by united effort and inherent creative genius, inspired by the needs of fellow Georgians.

In this renewed effort to raise a strong legislative voice, dedicated to the improvement of public health in Georgia and to the suppression of growing evils, painfully apparent, you and each of you are urged to enlist. A specific program will be presented soon. Keep your lamps "trimmed and burning".

Committee on Public Policy and  
Legislation,

C. W. ROBERTS, Chairman,  
W. E. McCURRY,  
J. W. PALMER.

#### THE USE OF EXTRACTS OF THE PITUITARY GLAND IN OBSTETRICS

According to J. Whitridge Williams, Baltimore (Journal A. M. A., Nov. 29, 1924), the use of pituitary extract in obstetrics should not be considered as harmless, since we are dealing with an extraordinarily potent agent, which is as yet imperfectly standardized. Williams regards as somewhat dubious its use in the treatment of prolonged labor even under the most favorable conditions, and as extraordinarily dangerous in the presence of disproportion or of malposition of the child. Its greatest field of usefulness is in the prevention and control of antonic hemorrhage following the third stage of labor, while it is relatively efficient in the induction of labor during the last week of pregnancy.

# Medical Association of Georgia

## Seventy-Sixth Annual Meeting Atlanta-Biltmore,

### May 13, 14, 15, 1925.

## OFFICIAL PROGRAM

### OFFICERS

President.....	J. O. Elrod, Forsyth
First Vice-President.....	W. A. Mulherin, Augusta
Second Vice-President.....	B. H. Wagon, Atlanta
Parliamentarian.....	M. A. Clark, Macon
Secretary-Treasurer.....	Allen H. Bunce, Atlanta

#### Delegates to American Medical Association

J. W. Palmer (1923-1924).....	Ailey
J. N. Brawner (1923-1924), Alternate.....	Atlanta
Allen H. Bunce (1924-1925).....	Atlanta
W. C. Lyle (1924-1925), Alternate.....	Atlanta

#### Committee on Arrangements

E. C. Thrash, Chairman
W. L. Funkhouser
Grady E. Clay
O. D. Hall
R. G. Stephens
Allen H. Bunce, Ex-Officio
Theo. Toepel, Ex-Officio

### OFFICERS

#### Fulton County Medical Society

President.....	Theo. Toepel
Vice-President.....	J. L. Campbell
Secretary-Treasurer.....	Grady E. Clay

### COUNCILLORS

First District.....	Chas. Usher, Savannah
Vice-Councillor.....	C. Thompson, Millen
Second District.....	C. K. Sharp, Arlington
Vice-Councillor.....	R. F. Wheat, Bainbridge
Third District.....	V. O. Harvard, Arabi
Vice-Councillor.....	J. F. Lunsford, Preston
Fourth District.....	O. W. Roberts, Carrollton
Vice-Councillor.....	J. A. Thrash, Columbus
Fifth District.....	W. C. Lyle, Atlanta
Vice-Councillor.....	W. A. Selman, Atlanta
Sixth District.....	M. M. Head, Zebulon
Vice-Councillor.....	J. M. Anderson, Barnesville
Seventh District.....	M. M. McCord, Rome
Vice-Councillor.....	J. H. Hammond, LaFayette
Eighth District.....	H. M. Fullilove, Athens
Vice-Councillor.....	J. S. Stewart, Jr., Athens
Ninth District.....	C. D. Whelchel, Gainesville
Vice-Councillor.....	W. J. Hutchins, Buford
Tenth District.....	S. J. Lewis, Augusta
Vice-Councillor.....	H. D. Allen, Jr., Milledgeville
Eleventh District.....	J. W. Simmons, Brunswick
Vice-Councillor.....	A. S. M. Coleman, Douglas
Twelfth District.....	T. C. Thompson, Vidalia
Vice-Councillor.....	J. Cox Wall, Eastman

#### Committee on Scientific Work

A. R. Rozar, Chairman.....	Macon
Hugh N. Page.....	Augusta
Allen H. Bunce, Secretary.....	Atlanta

### ANNOUNCEMENTS

Meetings will be held in the Atlanta-Biltmore.

Be sure to go to the Registration Desk, present your 1925 card and procure a badge immediately on your arrival.

Discussion of papers is open to all members and guests of the Association. It is not limited to those named on the program.

On arising to discuss a paper, the speaker will please announce his name and address clearly for the benefit of the Association and stenographer.

Sessions will be called to order at the hour fixed on the program. It is especially desired that the members be prompt in their attendance.

All manuscripts should be typewritten, double-spaced and on one side of the paper only. Papers must be handed to the Secretary immediately after being read.

#### IMPORTANT NOTICE!

Delegates must present written credentials to the Committee on Credentials from the House of Delegates to secure Delegates' Badges.

Members may not take part in the proceedings until they have registered and procured official badges.

#### Committee on Public Policy and Legislation

C. W. Roberts, Chairman.....	Atlanta
J. W. Palmer.....	Ailey
W. E. McCurry.....	Hartwell
J. O. Elrod, President.....	Forsyth
Allen H. Bunce, Secretary.....	Atlanta

#### Committee on Medical Defense

M. A. Clark, Chairman.....	Macon
E. C. Thrash.....	Atlanta
E. C. Davis.....	Atlanta
V. O. Harvard, Chairman, Council.....	Arabi
Allen H. Bunce, Secretary.....	Atlanta

#### Committee on Hospitals

H. H. McGee*, Chairman.....	Savannah
R. M. Harbin.....	Rome
C. Thompson.....	Millen

#### Committee on Necrology

R. L. Miller, Chairman.....	Waynesboro
R. F. Wheat.....	Bainbridge
Geo. B. Smith.....	Rome

#### Committee on Health and Public Instruction

Theo. Toepel, Chairman.....	Atlanta
H. B. Neagle.....	Augusta
J. A. Thrash.....	Columbus
J. O. Elrod, President.....	Forsyth
Allen H. Bunce, Secretary.....	Atlanta

\*DECEASED.

**Cancer Commission**

J. L. Campbell, Chairman	Atlanta
Chas. Usher	Savannah
C. K. Sharp	Arlington
T. J. McArthur	Cordele
J. M. Poer	West Point
C. H. Willis	Barnesville
W. H. Lewis	Rome
H. M. Fullilove	Athens
M. B. Allen	Hoschton
W. W. Battey	Augusta
A. C. Little	Valdosta
T. C. Thompson	Vidalia

**PUBLIC MEETINGS****Wednesday, May 13, 10:00 A. M.****Opening Session**

The session on Wednesday morning will be open to the public. All visitors are cordially invited.

**Thursday, May 14, 12:00 Noon****President's Address**

The President's Address will be at an open session to which the public and visitors are invited.

**ENTERTAINMENTS****Wednesday, May 13, 9:30 P. M.**

Smoker for those interested in Pediatrics by the Pediatric Section of the Fulton County Medical Society at the Atlanta-Biltmore.

**Thursday, May 14**

Banquet at 7 P. M., Atlanta-Biltmore. All members and guests must wear badges. Your badge will constitute your "admission ticket."

Toastmaster, Frank K. Boland.

"Tularaemia," Edward Francis, Surgeon, U. S. P. H. S., Washington, D. C., invited guest of the Association.

Presentation of "Badge of Service" to the President, J. O. Elrod, by W. S. Goldsmith.

Dance at 9:30 P. M., Atlanta-Biltmore (Informal).

**Friday, May 15, 1:00 P. M.****Health Parade****SPECIAL MEETINGS****Meeting of Secretaries of District and County Societies**

Round table conference of the Secretaries of District and County Societies. Wednesday, May 13, 5:30 P. M., in House of Delegates' room, Atlanta-Biltmore. All Secretaries of District and County Societies are expected to be present. Each one will be called upon for a report of conditions in his Society and suggestions for betterment of organization. The President, members of the Council and all general officers of the Association will be present.

**Meeting of the Council**

The first meeting of the Council will be held in the House of Delegates' room, Atlanta-Biltmore, Tuesday, May, 12, at 6:30 P. M. Each Councillor will render a written report of conditions in each County in his District. Other meetings of the Council will be held on the call of the Chairman.

**MEETINGS OF THE HOUSE OF DELEGATES****Tuesday, May 12, 7:30 P. M.**

First meeting of the House of Delegates.

1. Call to order by the President.
2. Roll Call.
3. Report of officers.
4. Report of Council.
5. Report of Committees.
  - a. Scientific Work.
  - b. Public Policy and Legislation.
  - c. Arrangements.
  - d. Medical Defense.

- e. Hospitals.
- f. Necrology.
- g. Health and Public Instruction.
- h. Cancer Commission.

6. Report of Delegates to the A. M. A.

7. Unfinished business.

8. New business.

**Wednesday, May 13, 8:00 A. M.**

Second meeting of the House of Delegates.

1. Call to order by the President.
2. Reading of minutes.
3. Report of Committees, continued.
4. Unfinished business.
5. New business.

**Thursday, May 14, 8:00 A. M.**

Third meeting of the House of Delegates.

1. Call to order by the President.
2. Reading of minutes.
3. Report of Committees, continued.
4. Unfinished business.
5. New business.

**PROGRAM**

The papers for each session shall be taken up as scheduled on program and each session must be completed before taking up the next session.

**WEDNESDAY, MAY 13****10:00 A. M.**

Meeting called to order by Dr. J. O. Elrod, Forsyth, President of the Association.

**Invocation**

Rabbi David Marx.....Atlanta

**Address of Welcome**

Theodore Toepel, President, Fulton County Medical Society.....Atlanta

**Response to Address of Welcome**

W. R. Dancy.....Savannah

**Scientific Papers**

1. Myxedema.  
Henry R. Slack, LaGrange.
2. Gastric and Duodenal Ulcer with the Medical Treatment.  
J. D. Gray, Augusta.
3. Infections of the Biliary Tract Unrelieved by Surgical Intervention.  
W. H. Lewis, Rome.
4. Case Reports: Blood Chemistry Findings in Vomiting of Pregnancy; Intestinal Obstruction; etc.  
John W. Daniel, Savannah.
5. Pellagra and Its Treatment.  
L. L. Whiddon, Ocilla.
6. Pediatrics and the Public Welfare.  
H. B. Neagle, Augusta.

**WEDNESDAY****2:30 P. M.**

7. The Athens Child Health Demonstration.  
Thos. Bolling Gay, Athens.
8. Intracranial Injuries in the New Born.  
C. H. Richardson, Jr., Macon.
9. Physiological Pigmentation of the New Born.  
M. Hines Roberts, Atlanta.
10. Pyuria in Infants and Children.  
W. W. Anderson, Atlanta.
11. The Treatment of Syphilis in Children; With Special Demonstration of Intraperitoneal Injections of Neoarsphenamine and Mercurosal.  
Joseph Yampolsky and Geo. F. Klugh, Atlanta.
12. Report of 2000 Infants Fed on Dry Milk.  
M. M. McCord, Rome.



**WEDNESDAY****7:30 P. M.**

13. Further Observations on the Management of Head Injuries.  
J. Calvin Weaver, Atlanta.
14. The Eye as an Index in the Study of Focal Infection. (Lantern Slides).  
H. H. Martin, Savannah.
15. Diagnostic Importance of the Pyelogram in Chronic Abdominal Conditions (Lantern Slides).  
Samuel J. Sinkoe, Atlanta.
16. Clinical and Pathological Observations on 100 Cases of Goiter (Lantern Slides).  
Chas. E. Waits and R. F. Leadingham, Atlanta.
17. Demonstration of Motion Pictures as a Valuable Aid in the Clinical Study of Cases and as a Method of Teaching.  
Chas. E. Dowman and Floyd W. McRae, Atlanta.

**THURSDAY, MAY 14****9:00 A. M.**

18. Dermatophytosis.  
Jack W. Jones, Atlanta.
19. The Treatment of Diabetes Mellitus.  
J. A. Redfearn, Albany.
20. Chronic Adhesive Mediastino-Pericarditis With Review of 150 Cases.  
E. E. Murphey, Augusta.
21. Treatment of Pneumonia.  
E. C. Thrash, Atlanta.

**President's Address at Noon Thursday, May 14****THURSDAY****2:30 P. M.**

22. The Dextrose Content of the Cerebrospinal Fluid in Certain Nervous and Mental Diseases.  
E. B. Saye, Milledgeville.
23. Hexylresorcinol in Bacillus Proteus Pyelitis with Report of Case.  
W. E. McCurry, Hartwell.
24. The Treatment of Pyelitis.  
Walter R. Holmes, Atlanta.
25. The Surgery of Inguinal Hernia.  
W. F. Westmoreland, Atlanta.
26. Local Anesthesia in Surgery.  
G. Y. Massenburg, Macon.
27. History-Taking by the General Practitioner.  
W. H. Clark, LaGrange.
28. Syphilis and the General Practitioner.  
Henry Levington, Savannah.

**FRIDAY, MAY 15****9:00 A. M.**

29. Cancer of the Pancreas and Bile Ducts.  
Dan C. Elkin, Atlanta.
30. Malignant Conditions of the Cecum, Colon and Appendix with Report of Cases.  
E. C. Davis, Atlanta.  
Surgery of the Colon.

**Walter E. Sistrunk, Mayo Clinic, Rochester, Minn., Invited Guest of the Association.**

31. Cysts of the Mesentery.

Chas. Usher, Savannah.

32. Diagnosis and Treatment of Maxillary Sinusitis.  
B. McH. Cline, Atlanta.**FRIDAY****12:00 Noon****Election of Officers**

President.

First Vice-President.

Second Vice-President.

Secretary-Treasurer.

Delegate to A. M. A.

Alternate.

Councillors for the Fifth, Sixth, Seventh and Eighth Districts.

Selection of meeting place for 1926.

**FRIDAY****3:00 P. M.**33. Some Views on Appendiceal Abscess.  
H. R. Donaldson, Atlanta.34. Appendicitis in Childhood.  
W. W. Battey, Jr., Augusta.35. A New and Rapid Method of Blood Transfusion.  
Walter A. Norton, Savannah.36. Results and Treatment by Radium of 429 Cases of Carcinoma of the Cervix Uteri.  
Arthur C. Primrose, Americus.**FRIDAY****5:00 P. M.**

Meeting of Council for purpose of organization and outlining work for ensuing year.

**Miscellaneous****Constitution and By-Laws**

Section 1. No address or paper before the Association shall occupy more than fifteen minutes in its delivery; and no member shall speak longer than five minutes, nor more than once on any one subject, except by unanimous consent.

Section 2. All papers read before the Association, or any of the sections, shall become its property. Each paper shall be deposited with the Secretary when read.

Section 3. The deliberations of this Association shall be governed by parliamentary usage as contained in Roberts' Rules of Order, when not in conflict with this Constitution and By-Laws.

No miscellaneous or business matters will be discussed before the scientific session, but will be referred to the House of Delegates.

**RESOLUTION ADOPTED 1921**

Resolved, That a member who sends in a title of a paper to be placed on the program and is not present to read the paper shall pay the penalty of not having an opportunity to appear on the program for two years, unless he presents an excuse acceptable to the Committee on Scientific Work.

A. R. Rozar, Chairman,

Hugh N. Page,

Allen H. Bunce, Secretary,

Committee on Scientific Work.

# First Annual Meeting of THE WOMAN'S AUXILIARY to the MEDICAL ASSOCIATION OF GEORGIA Atlanta-Biltmore

May 13, 14, 15, 1925

The Registration Committee will receive the visiting ladies at the Atlanta-Biltmore at the registration booth. Badges, information concerning banquet and other entertainments, meeting rooms, etc., may be obtained there.

## Wednesday, May 13, 1925

10 A. M. Meeting of the Executive Committee at the Atlanta-Biltmore. See Bulletin Board.

10:30 A. M. Meeting of the Delegates.

## Thursday, May 14, 1925

10 A. M. General Meeting of the Auxiliary to the Medical Association of Georgia at which the wives of all the members of the Medical Association are urged to attend. To be held at the Auditorium of the Woman's Club, Peachtree Street near 14th Street. Catch Peachtree to Brookwood, Peachtree to 17th and Peachtree to Piedmont Park cars.

Meeting called to order by Mrs. James N. Brawner, President of the State Auxiliary.

## Invocation

Address of Welcome from Atlanta—Mrs. Norman Sharp, President of the Atlanta Woman's Club.

Address of Welcome from Fulton County Auxiliary—Mrs. E. C. Thrash, President Auxiliary of the Fulton County Medical Society.

## Response to Addresses of Welcome

Mrs. Addine Myers, Savannah.

## Address

Dr. Stewart R. Roberts, President of the Southern Medical Association.

## Cooperation of the Women's Auxiliaries in the Health Educational

## Work of the State

Dr. T. F. Abercrombie, Commissioner of Health of the State of Georgia.

Report of the Committee on Constitution and By-Laws—Mrs. C. W. Roberts, Atlanta.

Report of the President—Mrs. James N. Brawner, Atlanta.

Report of the Secretary-Treasurer—Mrs. Allen H. Bunce, Atlanta.

Unfinished Business.

New Business.

Election of Officers.

## SOCIAL PROGRAM

## Wednesday, May 13, 1925

5 P. M. Informal tea at the Academy of Medicine on Howard Street. Automobiles will be in readiness at the Atlanta-Biltmore at 4:30 P. M. Ladies will please assemble there.

## Thursday, May 14, 1925

1 P. M. Luncheon at the Woman's Club on Peachtree Street. Special program. Ride about the city following the election of officers of the State Auxiliary.

7 P. M. Banquet at the Atlanta-Biltmore. Special program. Doctors will join their wives after the banquet for dancing.

## Friday, May 15, 1925

10:30 A. M. Ride to Stone Mountain. Leave from Atlanta-Biltmore. Ladies will please assemble there.

## UNUSUAL COMPLICATION FOLLOWING USUAL OPERATIVE PROCEDURE FOR VARICOSE VEINS

Two cases are cited by David Fisher and Edmund H. Mensing, Milwaukee (Journal A. M. A., March 7, 1925), which emphasize and strike home vividly the extreme importance of a careful investigation in so self-evident a condition as varicose veins. In one of the cases the man had been advised to have an operation for varicose veins before an ulcer developed. The physical examination was negative except for the extremities, which showed marked prominence and slight bulging of all the superficial veins, extending from both feet upward to a point about 8 cm. above Poupart's ligament. There was very little tortuosity. The leg was raised and drained of its blood; then constriction was applied to the saphenous opening, and the leg lowered. Even after ten minutes, the veins did not show any filing. This, of course, meant that the deep or perforating veins were thrombosed or varicose. In view of a history of typhoid, it was safe to assume that in this case the deep or perforating veins were thrombosed, preventing the filling of the superficial veins. Had this man been operated on, gangrene of the extremities would probably have resulted. In the second case an ill advised operation was followed by gangrene necessitating a mid thigh amputation. The physical suffering in the interim, because of the physical suffering in the interim, because of the failure in the first place to apply a very simple test to the circulation. The authors urge that in every case of varicose veins, the Trendelenburg test be applied to ascertain the condition of both the superficial and deep veins; and in case of doubt, when the collateral circulation extends above Poupart's ligament, and no intra-abdominal cause for venous obstruction exists, the deep veins should be suspected.

## THE BLOOD COUNT IN CARCINOMA OF THE ESOPHAGUS

In fifteen cases of squamous cell carcinoma of the esophagus examined by A. M. Master, New York (Journal A. M. A., March 7, 1925), it will be seen that the average blood count was 93 per cent hemoglobin; 5,040,000 red blood cells; color index, 0.94; 9,900 white blood cells; 72 per cent polymorphonuclears; 23 per cent lymphocytes, and 5 monocytes. The cases cited were strictly carcinoma of the esophagus and did not involve the cardia. The pathologic reports were squamous cell carcinoma apparently. A high hemoglobin and erythrocyte count, a color index of nearly 1, and a slight leukocytosis are the usual findings. In other words, the normal or high blood count in a neoplasm of the esophagus is the same as in a cardiospasm of functional or inflammatory origin. A normal blood count therefore does not rule out a new growth of the esophagus. In carcinoma of the stomach, a moderate to severe secondary anemia is found. In twenty-six cases of stomach cancer, the average count was 58 per cent hemoglobin, 3,370,000 red blood cells, color index 0.8, 11,300 white blood cells, 76 per cent polymorphonuclears, 21 per cent lymphocytes and 3 per cent monocytes. The cause of the high blood cell count in the esophageal cancer is probably a concentration of the blood produced by the patient's dysphagia, which prevents him from eating or drinking in comfort. Carcinoma at or near the cardia is usually adenocarcinoma of the stomach, and usually the blood count is one characteristic of this condition; i. e., a severe secondary anemia.

## District and County Societies

The Secretary of each county society shall report to the Journal of the Medical Association of Georgia full minutes of each meeting and forward to it all scientific

papers and discussions which the society shall consider worthy of publication.—Constitution and By-Laws, Chap. VII, Sec. 15.

1. Demmond, E. Carson, Savannah.
2. Wood, A. W., Albany.
3. Greer, Chas. A., Oglethorpe.
4. Blackmar, Francis B., Columbus.
5. Clay, Grady E., Atlanta.
6. Hawkins, T. I., Griffin.

7. McCord, M. M., Rome.
8. Carter, D. M., Madison.
9. Bennett, J. C., Jefferson.
10. Lee, F. Lansing, Augusta.
11. Penland, J. E., Waycross.
12. Cheek, O. H., Dublin.

### HONOR ROLL

The following is a list of 100 per cent counties for 1925. The date on which each became a 100 per cent society appears after the name of the society, together with the name of the Secretary:

1. Randolph County, Dr. G. Y. Moore, Cuthbert, December 9, 1924.
2. Dougherty County, Dr. J. A. Redfearn, Albany, December 10, 1924.
3. Pike County, Dr. M. M. Head, Zebulon, December 12, 1924.
4. Hart County, Dr. W. E. McCurry, Hartwell, January 3, 1925.
5. Warren County, Dr. A. W. Davis, Warrenton, January 14, 1925.
6. Monroe County, Dr. W. J. Smith, Juliette, January 14, 1925.
7. Upson County, Dr. B. C. Adams, Thomaston, March 30, 1925.

### SECOND DISTRICT MEDICAL SOCIETY

The annual session of the Second District Medical Society was held March 12, 1925, at 10 a. m., in the City Hall, Bainbridge. The following papers were read:

"Headache from Eye Strain and Treatment," by Dr. H. M. Moore, Thomasville.

"My Observation in the Use of Aeriflavine," by Dr. W. L. Wilkinson, Bainbridge.

"Nephritis, with Report of Cases," by Dr. J. W. Daniel, Savannah.

"Surgery of Pulmonary Diseases," by Dr. A. D. Little, Thomasville.

"Local Infection with Some Detailed Observations," by Dr. J. F. Covington, Moultrie.

At 1 o'clock a barbecue was served the guests by the Kiwanis and Lions Clubs at the Bainbridge Country Club, after which the following officers were elected:

President, Dr. C. K. Sharp, Arlington, succeeding Dr. Gordon Chason, Bainbridge.

Vice-President, Dr. J. A. Summerlin, Hartfield, succeeding Dr. M. M. Stuart, Moultrie.

Secretary-Treasurer, Dr. A. W. Wood, Albany, re-elected.

### NINTH DISTRICT MEDICAL SOCIETY

The members of the Hall County Medical Society were hosts to the Ninth District Medical Society at its semi-annual meeting held in the Community House at Gainesville, March 18, 1925. It was called to order by the President, Dr. Myron B. Allen, Hoschton, at 11 a. m. The Invocation was given by Rev. E. F. Campbell, Gainesville. Dr. J. B. Rudolph gave the Address of Welcome with the Response by Dr. L. W. Hodges, Winder. The Secretary, Dr. Jesse C. Bennett, Jefferson, then read the minutes of the last meeting and gave his report. The Scientific Program was as follows:

Dr. Edson W. Glidden, "The Relation of Childhood Tuberculosis to the General Tuberculosis Problem."

Dr. C. W. Strickler, Atlanta, "Arteriosclerosis."

Dr. Allen H. Bunce, Atlanta, "Personal Observation on Acute Leukemia."

Dr. Newdigate M. Owensby, Atlanta, "The Importance of Psychological Medicine to the General Practitioner."

Dr. J. K. Burns, Jr., Gainesville, "Empyema."

Dr. R. L. Rogers, Gainesville, "Transfusion in Secondary Enemia."

Dr. Bradley B. Davis, Gainesville, "Constipation in Infants."

Dinner was then enjoyed by all, during



which time the following officers were elected:

President, Dr. J. R. Simpson, Gainesville.

Vice-President, Dr. Edson W. Glidden, Alto.

Secretary-Treasurer, Dr. J. C. Bennett, Jefferson.

Tooeoa was decided upon as the next meeting place.

### COUNTY SOCIETIES REPORTING FOR 1925

We now have 1281 paid up members for 1925 compared with 995 through March 31, 1925, 448 through January 31, 1925 and 109 through December 31, 1924.

#### JENKINS COUNTY MEDICAL SOCIETY

✓ The Jenkins County Medical Society announces the following officers for 1925:

President—Dr. M. E. Perkins, Millen.

Vice-President—Dr. Q. A. Mulkey, Millen.

Secretary-Treasurer—Dr. C. Thompson, Millen.

Delegate—Dr. C. Thompson, Millen.

#### ✓ WHITFIELD COUNTY MEDICAL SOCIETY

The Whitfield County Medical Society announces the following officers for 1925:

President—Dr. Trammel Starr, Dalton.

Vice-President—Dr. J. C. Rollins, Dalton.

Secretary-Treasurer—Dr. B. L. Kennedy, Dalton.

Delegate—Dr. J. C. Rollins, Dalton; Alternate—Dr. B. L. Kennedy, Dalton.

Board of Censors—Drs. H. L. Erwin, B. L. Kennedy and J. H. Steed.

#### ✓ MORGAN COUNTY MEDICAL SOCIETY

The Morgan County Medical Society announces the following officers for 1925:

President—Drs. W. M. Fambrough, Bostwick.

Vice-President—Dr. W. C. McGeary, Madison.

Secretary-Treasurer—Dr. D. M. Carter, Madison.

Delegate—Dr. J. L. Porter, Rutledge; Alternate—Dr. W. C. McGeary, Madison.

#### ✓ DOOLY COUNTY MEDICAL SOCIETY

The Dooly County Medical Society announces the following officers for 1925:

President—Dr. R. H. Pate, Unadilla.

Vice-President—Dr. J. L. Lee, Pinchurst.

Secretary-Treasurer—Dr. F. E. Williams, Vienna.

#### ✓ POLK COUNTY MEDICAL SOCIETY

The Polk County Medical Society announces the following officers for 1925:

President—Dr. S. L. Whitely, Cedartown.

Vice-President—Dr. C. W. Peek, Cedartown.

Secretary-Treasurer—Dr. John W. Good, Cedartown.

Delegate—Dr. E. H. Richardson, Cedartown; Alternate—Dr. T. E. McBryde, Rockmart.

#### ✓ EMANUEL COUNTY MEDICAL SOCIETY

The Emanuel County Medical Society announces the following officers for 1925:

President—Dr. J. D. Bailey, Summertown.

Vice-President—Dr. J. M. Nunez, Swainsboro.

Secretary-Treasurer—Dr. S. S. Youman, Oak Park.

Delegate—Dr. E. T. Coleman, Graymont.

#### ✓ MITCHELL COUNTY MEDICAL SOCIETY

The Mitchell County Medical Society announces the following officers for 1925:

President—Dr. O. G. Crawford, Sale City.

Secretary-Treasurer—Dr. D. P. Luke, Camilla.

#### ✓ COBB COUNTY MEDICAL SOCIETY

The Cobb County Medical Society announces the following officers for 1925:

President—Dr. W. H. Perkinson, Marietta.

Vice-President—Dr. F. P. Lindley, Powder Springs.

Secretary-Treasurer—Dr. R. W. Fowler, Marietta.

Delegate—Dr. L. L. Blair, Marietta; Alternate—Dr. R. W. Fowler, Marietta.

Board of Censors—Drs. C. T. Nolan, Frank Mims, W. H. Kemp.

✓ **Macon-Taylor Counties Medical Society**

The Macon-Taylor Counties Medical Society announces the following officers for 1925:

President, Dr. C. A. Greer, Oglethorpe.  
Vice-President, Dr. R. C. Montgomery, Butler.

Secretary-Treasurer, Dr. F. M. Mullino, Montezuma.

Delegate, Dr. C. H. Richardson, Sr., Montezuma.

Alternate, Dr. J. E. Mangham, Reynolds.

Board of Censors, Drs. S. H. Bryan, Reynolds; R. E. McGill, Montezuma and C. H. Richardson, Sr., Montezuma.

✓ **Forsyth County Medical Society**

Dr. Mashburn in his report states that Forsyth County is 100 per cent with the exception of one doctor. The following officers were announced for 1925:

President, Dr. W. E. Lipscomb, Cummings.  
Secretary-Treasurer, Dr. Marcus Mashburn, Cummings.

✓ **Ben Hill County Medical Society**

The Ben Hill County Medical Society announces the following officers for 1925:

President, Dr. W. P. Coffee, Fitzgerald.  
Vice-President, Dr. E. A. Russell, Fitzgerald.

Secretary-Treasurer, Dr. L. S. Osborne, Fitzgerald.

Delegate, Dr. E. J. Dorminy, Fitzgerald.

Alternate, Dr. Frank Ward, Fitzgerald.

Board of Censors, Drs. E. J. Dorminy, Fitzgerald, and Frank Ward, Fitzgerald.

✓ **Walton County Medical Society**

The Walton County Medical Society announces the following officers for 1925:

President, Dr. H. L. Upshaw, Social Circle.  
Vice-President, Dr. J. B. H. Day, Social Circle.

Secretary-Treasurer, Dr. J. K. McClintic, Monroe.

Delegate, Dr. W. K. Swann, Monroe.

Alternate, Dr. T. R. Aycock, Monroe.

Board of Censors, Drs. T. R. Aycock, Monroe; G. R. Wells, Monroe, and W. K. Swann, Monroe.

✓ **Upson County Medical Society—100%**

We are glad to add Upson County to our Honor Roll as the 7th Society reporting 100% membership for 1925. They announce the following officers:

President, Dr. R. L. Carter, Thomaston.  
Vice-President, Dr. C. A. Harris, The Rock.

Secretary-Treasurer, Dr. B. C. Adams, Thomaston.

Delegate, Dr. C. A. Harris, The Rock.

Alternate, Dr. R. L. Carter, Thomaston.

Board of Censors, Drs. K. S. Williams, Thomaston; A. H. Black, Thomaston, and J. M. McKenzie, Thomaston.

✓ **Baldwin County Medical Society**

The Baldwin County Medical Society announces the following officers for 1925:

President, Dr. N. P. Walker, Milledgeville.  
Vice-President, Dr. W. M. Scott, Deveraux.

Secretary-Treasurer, Dr. H. D. Allen, Jr., Milledgeville.

Delegate, Dr. Geo. L. Echols, Milledgeville.

Alternate, Dr. E. B. Saye, Milledgeville.

Board of Censors, Drs. R. C. Swint, Milledgeville; H. D. Allen, Jr., Milledgeville, and E. W. Allen, Milledgeville.

✓ **Ware County Medical Society**

The Ware County Medical Society announces the following officers for 1925:

President, Dr. K. McCullough, Waycross.  
Vice-President, Dr. W. D. Mixson, Waycross.

Secretary-Treasurer, Dr. J. E. Penland, Waycross.

Delegate, Dr. W. F. Reavis, Waycross.

Board of Censors, Drs. C. M. Stephens, Waycross; R. C. Walker, Waycross, and H. J. Carswell, Waycross.

✓ **Ocmulgee County Medical Society**

The Ocmulgee County Medical Society announces the following officers for 1925:

President, Dr. W. A. Mathews, Hawkinsville.

Vice-President, Dr. W. A. Coleman, Eastman.

Secretary-Treasurer, Dr. W. H. Pirkle, Cochran.

Delegate, Dr. W. A. Coleman, Eastman.  
Alternate, Dr. W. H. Pirkle, Cochran.

Board of Censors, Drs. A. L. Smith, Cochran; E. C. Brown, Hawkinsville, and J. Cox Wall, Eastman.

#### ✓ **Jones County Medical Society**

The Jones County Medical Society announces the following officers for 1925:

President, Dr. J. H. Riley, Haddock.

Secretary-Treasurer, Dr. P. R. Chambliss, Gray.

Delegate, Dr. J. D. Zaekary, Bradley.

#### ✓ **Lamar County Medical Society**

The Lamar County Medical Society announces the following officers for 1925:

President, Dr. C. E. Suggs, Barnesville.

Vice-President, Dr. J. M. F. Barron, Milner, R. F. D.

Secretary-Treasurer, Dr. J. M. Anderson, Barnesville.

Delegate, Dr. C. H. Willis, Barnesville.

Board of Censors, Drs. J. A. Corry, Barnesville; D. W. Pritchett, Barnesville, and J. M. Rogers, Barnesville.

#### ✓ **Decatur-Seminole Counties Medical Society**

The Decatur-Seminole Counties Society announces the following officers for 1925:

President, Dr. S. A. V. Christophine, Atapulgus.

Vice-President, Dr. W. L. Wilkinson, Bainbridge.

Secretary-Treasurer, Dr. L. W. Willis, Bainbridge.

#### ✓ **DeKalb County Medical Society**

The DeKalb County Medical Society announces the following officers for 1925.

President, Dr. Mary F. Sweet, Decatur.

Vice-President, Dr. J. C. Daniel, Decatur.

Secretary-Treasurer, Dr. J. F. Pitman, Decatur.

Delegate, Dr. C. E. Pattillo, Decatur.

Alternate, Dr. J. E. Pounds, Decatur.

Board of Censors, Drs. W. S. Ansley, Decatur; C. L. Allgood, Scottdale, and J. E. Pounds, Decatur.

#### ✓ **Tatnall County Medical Society**

The Tatnall County Medical Society has been issued a Charter as it has formed a Society of its own and is no longer connected with the Evans County Medical Society. The Tatnall Society announces the following officers for 1925:

President, Dr. J. M. Hughes, Glennville.

Secretary-Treasurer, Dr. P. H. Smith, Glennville.

Delegate, Dr. L. V. Strickland, Cobbtown.

Alternate, Dr. P. H. Smith, Glennville.

#### ✓ **Toombs County Medical Society**

The Toombs County Medical Society announces the following officers for 1925:

President, Dr. J. E. Mercer, Vidalia.

Secretary-Treasurer, Dr. W. W. Odom, Lyons.

#### ✓ **Bibb County Medical Society**

The Bibb County Medical Society announces the following officers for 1925:

President, Dr. Benjamin Bashinski, Macon.

Vice-President, Dr. O. R. Tohmppson, Macon.

Secretary-Treasurer, Dr. R. S. Muekenfuss, Macon.

#### ✓ **Coffee County Medical Society**

The Coffee County Medical Society announces the following officers for 1925:

President, Dr. Geo. M. Ricketson, Broxton.

Vice-President, Dr. W. F. Sibbett, Douglas.

Secretary-Treasurer, Dr. T. H. Clark, Douglas.

Delegate, Dr. John R. Smith, Douglas.

Board of Censors, Drs. A. S. M. Coleman, Douglas; H. C. Wheelchel, Douglas; C. C. Giddens, Broxton.

#### ✓ **Spalding County Medical Society**

The Spalding County Medical Society announces the following officers for 1925:

President, Dr. K. S. Hunt, Griffin.

Vice-President, Dr. W. C. Miles, Griffin.

Secretary-Treasurer, Dr. T. I. Hawkins, Griffin.



Delegate, Dr. A. H. Frye, Griffin.

Alternate, Dr. J. R. Anthony, Griffin.

Board of Censors, Drs. L. M. Gable, Brooks Station; W. H. Austin, Griffin, and Webb Conn, Griffin.

### ✓ Johnson County Medical Society

The Johnson County Medical Society announces the following officers for 1925:

President, Dr. T. L. Harris, Wrightsville.

Vice-President, Dr. D. C. Harrison, Kite.

Secretary-Treasurer, Dr. J. G. Brantley, Wrightsville.

Delegate, Dr. R. E. Brinson, Wrightsville.

Alternate, Dr. H. B. Bray, Wrightsville.

### ✓ Washington County Medical Society

The Washington County Medical Society announces the following officers for 1925:

President, Dr. T. B. King, Sandersville.

Vice-President, Dr. B. O. Joiner, Tennille.

Secretary-Treasurer, Dr. N. Overby, Sandersville.

Delegate, Dr. J. R. Burdette, Tennille.

Alternate, Dr. B. L. Helton.

Board of Censors, Drs. W. B. Warthen, Davisboro; E. S. Peacock, Harrison; R. L. Taylor, Davisboro.

### ✓ Clarke County Medical Society

The Clarke County Medical Society announces the following officers for 1925:

President, Dr. Harrold I. Reynolds, Athens.

Vice-President, Dr. C. J. Decker, Athens.

Secretary-Treasurer, Dr. Thos. Bolling Gay, Athens.

Delegate, Dr. Ralph M. Goss, Athens.

Alternate, Dr. A. A. Rayle.

Board of Censors, Drs. M. F. Matthews, Athens; J. D. Applewhite, Athens, and W. H. Cabaniss, Athens.

### ✓ A CORRECTION

In giving the list of officers for 1925 of Turner and Crisp Counties, in the February issue of the Journal, Dr. J. H. Baxter, of Ashburn, was named as Secretary-Treasurer of both Societies. This was an error as Dr. B. Daniel, of Cordele, is Secretary-Treasurer of Crisp County, having been re-elected.

### Fulton County Medical Society

A very interesting meeting of the Fulton County Medical Society was held March 5th, 1925, at the Academy of Medicine, 32 Howard St., Atlanta, Ga. The president, Dr. Theo Toepel, presided and there were 149 present.

Dr. J. L. Campbell gave a case report, "Cancer of the Stomach with Exhibition of a Specimen," which was discussed by Drs. Clark, Willis Jones, J. W. Roberts, J. W. Ellis, B. H. Wagnon and C. W. Roberts. Dr. Jas. A. Combs read a paper on "Dystocia Due to Developmental Defects in the Fetus, with Report of a Case." This was discussed by Drs. Bartholomew, Shallenberger, Upshaw, Fanning. "Treatment of Pyelitis" was the title of a paper read by Dr. W. R. Holmes. This paper was discussed by Drs. Estes, E. G. Ballenger, Shallenberger, Emery, Floyd, Wagnon.

Several announcements of importance were made: Dr. Toepel called the attention of the members to the second meeting in March which will be known as the 5th District Meeting, also, to the call meeting for March 23rd, at which time Dr. Albee will address the Society on "Advances of Reconstruction."

After the report of Committees the motion was to adjourn.

Respectfully submitted,

GRADY E. CLAY, Secretary.

### BLOOD PRESSURE MAINTENANCE IN SPINAL ANESTHESIA

A fall of blood pressure accompanies each spinal anesthesia. It is the one possible danger associated with this form of anesthesia and may cause death. Its low point is usually ten minutes after the injection, and most fatalities have occurred at that time. Epinephrin given intravenously is the only reliable drug in desperate cases of blood pressure collapse. Promptly and properly administered, it will hold every case until the body vasomotor tone is naturally restored. But the occasional near fatality which every user of spinal anesthetics has seen has resulted in the clinical trial of many drugs and measures to anticipate this blood pressure drop. During the last two years William A. Steel, Philadelphia (Journal A. M. A., Jan. 10, 1925), used primary ether anesthesia as a routine to all suspected bad risks, especially in upper abdominal cases; i. e., gallbladder and stomach surgery. It has an added advantage in blocking out consciousness when the preliminary morphin narcosis is not effectual, and so lessens psychic shock. The average blood pressure chart of thirty recent abdominal, pelvic and leg operations, when primary ether was given, shows a gain of eight points in the diastolic and twenty points in the systolic blood pressure over the thirty cases in which hypodermic stimulants were used. Ten minutes of ether is the best prophylactic method to maintain blood pressure in spinal anesthesia.

## Medical Progress

With the cooperation of our associates we propose to publish under "Medical Progress" abstracts from current medical literature of general interest to the

profession. Members of the association are invited to contribute to this Department.

Anderson, W. W., Pediatrics  
Ballenger, E. G., Urology  
Bartholomew, R. A., Obstetrics  
Block, E. B., Neurology and Psychiatry  
Clay, Grady E., Ophthalmology  
Downman, C. E., Neuro-Surgery  
Eques, M. S., Otology, Laryngology and Rhinology  
Fitts, Jno. B., Internal Medicine  
Greene, E. H., Surgery

Hodgson, F. G., Orthopedics  
Holmes, Walter R., Gynecology and Female Urology  
Jones, Jack W., Dermatology  
Klugh, Geo. F., Clinical Pathology  
Landham, J. W., X-Ray and Radium  
Pruitt, M. C., Proctology  
Thrash, E. C., Internal Medicine  
Waits, C. E., Surgery

### PROGRESS IN OBSTETRICS—1924

(continued from March issue, page 127)

Cardiac disease, even though there may be some decompensation at times is not incompatible with pregnancy progressing to full term and terminating by normal labor, provided the cardiac reserve is protected by strict rest and the use of digitalis when indicated. It should be a rule not to attempt delivery of a patient during an attack of decompensation, but first re-establish compensation by the usual measures of rest, morphine and digitalis. In general, delivery should be natural and conservative rather than by abdominal or vaginal section, since the recovery will be less likely to be complicated by vomiting, etc., which would be an added strain on the heart. By the use of morphine in the first stage and forceps in the second stage, the strain of labor need not be so great. Cesarean section is recommended by some on account of the advantage of being able to sterilize the patient and prevent future pregnancies, but this can be accomplished just as effectively by subsequent roentgen ray or radium treatment without any risk. The care of cardiac cases in some of the larger clinics has been greatly facilitated by cooperation of the internists in the hospital, and some of the best articles on this subject have come from such joint and cooperative work.

Pain in labor can be controlled to a great extent in hospitals where nitrous oxide or ethylene is available, or facilities make it possible to use a modification of twilight sleep, but satisfactory results are more difficult to obtain in deliveries in the homes where proper facilities are not available. Gwathmey's "Painless Childbirth by Syner-

gistic Methods," (American Journal of Obstetrics and Gynecology, August 1924), is an effort to perfect a method suitable for use in general practice. Although the method is safe and efficient, its use would demand considerably more of the practitioner's time than is now devoted to such cases. Injections of novocain solution in the sacral canal through the sacral hiatus, as described by Meeker and Bonar in Surgery, Gynecology and Obstetrics, December 1923, is a simple, safe and efficient procedure for the second stage, provided its administration can be properly timed. Ethylene apparently does not have sufficient advantages over nitrous oxide to compensate for the added danger of explosions which may occur. Much relief can be given patients by the use of an injection of morphine gr. 1/8 to 1/6 and scopolamine gr. 1/300 to 1/400 given in 1 c.c. of 50 per cent magnesium sulphate solution which can be obtained in ampule form and greatly enhances and prolongs the effect of the above drugs when given early in the first stage. This, combined with the use of ether for the delivery, affords considerable relief from the pain of labor.

Pituitrin is restricted to the third stage of labor in many clinics and by many authorities on account of the occasional violent and uncontrollable uterine contractions attending its injection, which occasionally leads to rupture of the uterus or possible asphyxia of the baby. Where it is used before birth of the child, there should be no obstruction to delivery from the soft or bony parts and no abnormalities in the size, presentation or condition of the baby.

Important modifications in the technique of breech extraction have come about, both through the observations of Potter on version and through autopsy studies on infants stillborn or dying soon after breech extraction. Whereas, formerly it has been thought that death in breech delivery was almost invariably the result of asphyxia from pressure on the umbilical cord, it is now known that the great majority of such babies die from the effects of the trauma of extraction, as rupture of tentorium, supra and infra-tentorial hemorrhage, fracture of cervical vertebrae and rupture of the spinal cord. Where formerly it has been taught that eight minutes was the upper limit of the infant's ability to survive during breech extraction, Potter has shown that fifteen to twenty minutes may be taken to extract the infant, with no subsequent asphyxia. Undue haste has therefore been the cause of serious injury to the baby and the principal cause of death. The subject is convincingly presented by Pierson in *Surgery, Gynecology and Obstetrics*, December, 1923. Incidentally, this places a higher value upon external version in the prophylaxis of breech presentation, and emphasizes its importance in prenatal care.

Statistics are accumulating from the larger clinics, notably by De Lee, Hirst and Beck, indicating the advantages of cesarean section by a low, cervical incision in the area exposed by incising the vesico-uterine peritoneal fold and pushing down the bladder, rather than by the high incision of the classical cesarean section. This modification is proving to be a valuable aid in preventing general peritonitis, even in cases potentially or actually infected, and reports by De Lee in a series of several hundred cases show a much lower mortality than with the classical operation. It is of great value in that it permits a thorough test of labor preceding operation. In view of the increasing frequency of reports of rupture of the uterus in subsequent pregnancy or labor following the classical operation, (Hillis;—*Surgery,*

*Gynecology and Obstetrics*, July 1924), and the lessened frequency of rupture in the low cervical section, De Lee contends that the latter operation should be the routine method.

The prophylaxis of puerperal sepsis continues to be of the greatest importance, inasmuch as there has been no specific curative treatment discovered. Intravenous injections of mereurochrome or gentian violet have been recommended, but are apparently of more value in thrombophlebitis than in the other forms of puerperal infection.

In view of the increasing interest manifested by the laity in the problem of better obstetrics, there is promise of better co-operation between the medical and the lay organizations, to make the advances of modern obstetrics available not only to the wealthy and the charity patients but to the middle class who stand in greatest need of adequate service.

R. A. BARTHOLOMEW.

---

#### NEWS ITEMS

The many friends of Dr. J. G. Dean, of Dawson, are sympathizing with him in the recent death of his wife. Dr. Dean is one of our Ex-Presidents and has been serving for the past several years as President and Delegate of the Terrell County Medical Society.

Dr. W. F. Wells, Hapeville, has been elected President of the 5th District Medical Society; Dr. D. Houseworth, Douglasville, Vice-President; Dr. John B. Fitts, Atlanta, Secretary-Treasurer, and Dr. E. C. Thrash, Atlanta, nominated as Councillor.

Dr. M. M. McCord was appointed President of the Emory University Alumni Association for Rome at the annual dinner held during January. He succeeds Dr. Ross P. Cox.

Dr. Leon Edward Brawner is being welcomed to Cairo after an absence of nearly 3 years. Dr. Brawner took a special course in the diseases of the eye, ear, nose and throat at the Harvard Post-Graduate Medical School, Boston, Mass. After serving a 19 months internship in the Massachusetts Eye, and Ear Infirmary, as Resident Surgeon, he returned to Cairo to practice. He is contemplating moving to Atlanta in the near future.



Dr. Robert O. Simmons, Rome, was elected President of the Floyd County Medical Society at the December meeting. Dr. A. F. Routledge, Rome, was named Vice-President and Dr. J. Harry Mull, Rome, was re-elected Secretary-Treasurer.

Dr. Jack W. Jones announces the removal of his offices from the Atlanta Trust Co. Building to 1108-1111 Atlanta National Bank Building. Practice limited to Dermatology.

Dr. S. J. Lewis, with offices in the Lamar Building, Augusta, announces that he is now limiting his practice to diseases of the Eye, Ear, Nose and Throat. Dr. Lewis is the Councillor from the Tenth District.

Dr. A. J. Ayers, who served as Pathologist to Grady Hospital for a number of years, has opened a clinical laboratory in the Hurt Building, Atlanta. Practice limited to Clinical Pathology. Dr. Ayers is a member of the Fulton County Medical Society.

In a letter from Dr. E. R. Anthony, Sr., of Griffin and an honorary member of the Spalding County Medical Society, he states that his son, Dr. E. R. Anthony, Jr., who is in the U. S. P. H. S., has been transferred from New Mexico to Marine Hospital No. 43, Ellis Island, N. Y.

Dr. Albert S. Bacon has recently returned from a Post-Graduate course and opened offices in the Davis-Exchange Bank Building, Albany. Practice limited to diseases of the Eye, Ear, Nose and Throat.

The many friends of Dr. B. W. Penn, Rome, regret very much his continued serious illness at an Atlanta hospital and wish him a speedy recovery. He is a member of the Floyd County Medical Society.

Drs. William M. Folks, Waycross; Marion T. Benson, Atlanta; G. Pope Huguley, Atlanta; O. H. Matthews, Atlanta; Geo. H. Noble, Atlanta, and Dunbar Roy, Atlanta, have been named on the Georgia Governing Committee of the Gorgas Memorial Institute, of which President Coolidge is the titular head.

Dr. Ben Bashinski, Macon, gave a lecture to the Pre-School Circle of the South Macon School, Friday, February 22nd. Many beneficial points to the mothers present were brought out. Dr. Bashinski is the newly elected President of the Bibb County Medical Society.

Dr. Thos. D. Coleman is being congratulated upon having been appointed as a medical officer, with the rank of Colonel, in the United States

regular army. Dr. Coleman is from Augusta and is one of the past Presidents of the Association.

Dr. A. C. Shamblin, Rome, has recently been honored by being elected to the Kiwanis Club of Rome.

Dr. C. L. Drew has opened offices in the New Theatre Building in Waycross. He is a graduate of the Maryland Medical College, of Baltimore, and has taken post-graduate work at the New York Post-Graduate School, at Smith's Infirmary on Staten Island and at the New Orleans Clinic. Dr. Drew located in Waycross in 1922 and limits his practice to Kidney and Bladder diseases.

Dr. A. G. Little, Valdosta, entertained the members of the Lowndes County Medical Society, of which he is President, at a dinner on February 10, 1925, at the Valdes Hotel. An interesting paper on diabetes was read by Dr. T. M. Talbot. 12 members enjoyed Dr. Little's hospitality.

The friends of Dr. Ross P. Cox, Rome, regret to learn of the recent death of his son, Ross P. Cox, Jr., who died at a government hospital in Tucson, Arizona, after a lingering illness of about two years. His body was brought to Rome for burial. He lacked only one term of graduating from Jefferson Medical College. Dr. Cox is a member of the Floyd County Medical Society.

Dr. Warren S. Dorrough announces the opening of his office at Suite 35 Doctors Building, 436 Peachtree Street, Atlanta, for the practice of Medicine and Surgery. He is being welcomed as a new member of the Fulton County Medical Society.

Drs. Raymond L. Johnson and William M. Folks attended the sectional meeting of the American College of Surgeons, held February 13th and 14th in Mobile, Alabama. Both are members of the Ware County Medical Society.

Dr. M. M. McCord recently addressed the Medical Societies of Gordon, Polk and Bartow Counties, as Councillor of the 7th District. He also addressed the Parent-Teacher Associations at Calhoun, Cedartown and Cartersville on the care of children with reference to pre-school age as well as school age.

Dr. W. R. Beddingfield, formerly of Wrightsville, has moved to Augusta and opened offices in the Lamar Building, to limit his practice to the treatment of the eye. He was graduated from the Medical Department of the University of Georgia in 1920 and has spent 2 years at the Eye and Ear Infirmary in New York. He will become affiliated with the Richmond County Medical Society.

Dr. C. H. McArthur is making plans to remove from Armuchee to Rome. He will be associated with Drs. A. F. Routledge and J. L. Chandler. Dr. McArthur will continue his membership with the Floyd Medical Society, as he is not leaving the County.

Dr. William H. Myers, Savannah, was re-elected Chairman of the Health Center at the annual meeting held February 16, 1925. Dr. J. N. Carter, also of Savannah, was named as one of the Executive Committee.

An infirmary is being built on the campus of the South Georgia College, McRae. It will consist of two wings connected by a reception room. One wing will be for girls and one for boys.

Dr. H. C. McCrackin, Baxley, has opened his new sanitarium, the McCrackin Sanitarium. Dr. McCrackin has associated with him: Drs. John M. Hall, Hazlehurst; P. H. Comas, Baxley; W. C. Pirkle, Baxley; W. D. Brach, Baxley, and J. L. Weaver, Baxley; all members of the Altamaha County Medical Society.

Dr. H. J. Carswell, Waycross, has moved his offices to the new Theatre Building. He was graduated from the University of Georgia Medical School and has taken 4 courses of post-graduate work in New York, 2 in Chicago, 3 at the Mayo Clinic and 1 in Cleveland. Dr. Carswell is State Senator from his District and a member of the Ware County Medical Society.

The First National Bank Office Building has been completed at Rome and is modern in all respects. Drs. W. J. Shaw, Geo. B. Smith, M. M. McCord, J. T. McCall, J. H. Mull, A. C. Shamblin, W. B. Floyd, A. H. Dellinger, J. L. Garrard and R. C. Maddox now have offices in this new building.

The Ocmulgee County Medical Society held its annual meeting March 3, 1925, at the Pulaski Hotel. It was presided over by Dr. W. A. Mathews, of Hawkinsville, who is President. Papers were read by Drs. W. A. Coleman, Eastman; R. L. Whipple, Cochran, and E. C. Brown, Hawkinsville. Dr. W. H. Pirkle, Cochran, is Secretary-Treasurer and Dr. W. A. Coleman, Eastman, Vice-President and Delegate.

Dr. C. F. Griffith, Griffin, has been appointed to complete the Staff of the Griffin Hospital. This announcement was made by Dr. J. R. Anthony, Griffin, Vice-Chairman of the Board of Control of the Hospital. Other members of the Staff include Drs. J. R. Anthony, A. H. Frye, W. C. Miles, K. S. Hunt, T. I. Hawkins, L. M. Gable and Webb Conn, all of Griffin and members of the Spalding County Medical Society.

The monthly meetings of the Richmond County Medical Society now consist of a combined dinner and scientific program. The meetings are now better attended than at any time in the history of the Society. Drs. W. H. Goodrich and H. B. Neagle, of Augusta, presented papers at the recent meeting.

An increase of \$5,235 was appropriated by the Bibb County Commissioners at their monthly meeting, March 3, 1925. This money will be used to carry out the new and extended county health program as outlined by Dr. C. L. Ridley, Macon, City-County Health Officer.

The Georgia Eclectic Medical Association will hold its 60th annual convention in Atlanta, April 15-16th, as announced by Dr. John Powell, Atlanta, Secretary of the Association. Headquarters will be in the Kimball House. Among the doctors to present papers are: Drs. A. F. White, Flovilla; O. B. Walker, Bowman; R. M. Moore, Waleska; L. P. Baker, Atlanta; J. G. Brantley, Wrightsville; John Powell, Atlanta, and Wiley Quillian, Lula.

The Georgia Medical Society (Chatham County) held a meeting March 24, 1925, at the rooms of the Society on Drayton Street. Papers were read by Drs. Charles Usher and J. R. Graves, of Savannah.

The Steiner Cancer Clinic at Grady Hospital, Atlanta, may become a state-wide institution. Now it is only a city institution. It will require about \$25,000 a year to carry out this plan and this question will be brought before the next session of the Legislature.

Dr. E. B. Claxton, Dublin, has moved into his new offices in the Dublin Clinic. He has had these office remodeled to suit his own needs. Dr. Claxton is a member of the Laurens County Medical Society.

Drs. H. T. Edmondson, Moultrie; W. H. Whitendale, Norman Park, and M. H. Stuart, Moultrie, read interesting papers before the meeting of the Colquitt County Medical Society, March 11, 1925. This was the largest attended meeting of the year.

Plans are being perfected by Dr. C. A. Greer, Macon County Health Officer, to hold a clinic in the various schools of the County. Dr. Greer is a resident of Oglethorpe and a member of the Macon-Taylor Medical Society.

A call meeting of the Fulton County Medical Society was held when it had as its guest, Dr.

Fred H. Albee, of New York and professor in Orthopedic Surgery at the New York Post-Graduate School. At a banquet in honor of Dr. Albee, short talks were made by Drs. E. C. Thrash, Garnett Quillian, T. C. Davison and Frank Eskridge. Dr. Albee was accompanied by 14 other prominent physicians and surgeons, one of their principal objects being to examine the methods employed by Dr. Michael Hoke in the treatment of patients at the Scottish Rite Hospital for Crippled Children.

A city sanitary inspector has been put on by the American Board of Health, of which Dr. J. W. Chambliss, of Americus, is Chairman. Dr. Chambliss is a member of the Sumter County Medical Society.

A County Health Department has been organized in Ware County under the requirements of the Ellis Health Bill. An appropriation of \$6,000 has been made jointly by Ware County and Waycross for the purpose of equipping a laboratory and defraying the expenses of the Department.

Dr. J. D. Applewhite, of Athens, and County Health Officer, has been appointed on the Committee to select a site and supervise the construction of the \$50,000 tuberculosis hospital for Clarke County.

The State Sanitarium at Alto, for tuberculous patients, cost the State \$46,144 for operation during 1924, or \$1.43 per day for each patient there.

The Burke County Medical Society met March 13, 1925, in the office of Dr. H. J. Morton, Waynesboro. Dr. W. R. Lowe, Midville, President, presided. Dr. J. M. Cook, Sardis, is the Vice-President, and Dr. J. B. Lewis, Waynesboro, Secretary-Treasurer. The physicians attending other than the members were: W. R. Lowe, Midville; W. H. Sutton, Midville; W. C. McCarver, Vidette, and J. M. Cook, Sardis.

### BOOK REVIEWS

**Diseases of the Skin**, by Richard L. Sutton, M. D. Fourth edition, Revised and Enlarged. C. V. Mosby Co., St. Louis, publishers.

As in previous editions, the author has searched recent literature and included in this edition all information which is worth while to those interested in dermatology.

The subject so presented makes the text attractive and easy to read. It is well illustrated. Having enjoyed a large practice

over a number of years the author has been able to give us a practical text. Nevertheless, the views of other authorities have not been neglected. The book includes all the information of the smaller texts while at the same time presents that which is essential and found in the larger ones.

Wm. HOWARD HAILEY.

**Rhus Dermatitis (Poison Ivy)**, by James B. McNair, M. D. The University of Chicago Press. Chicago, publishers.

This book is the result of a thorough study of rhus poisoning covering a period of several years. The work was done from the standpoint of pharmacology, botany and chemistry.

The author proves, without a reasonable doubt, that rhus poisoning results from contact with a sap which is non-volatile. This one fact makes the book worthwhile. It merits the attention of all physicians who treat diseases of the skin.

Wm. HOWARD HAILEY.

**PHYSIOLOGY AND BIOCHEMISTRY IN MODERN MEDICINE**, J. J. R. Macleod, Fourth edition, C. V. Mosby Company, St. Louis, 1922. 992 pages and 243 illustrations including 9 plates in color.

The purpose of this excellent volume is well defined in its preface: "The work is not intended to be a substitute, either for the regular text books in physiology, or for those in functional pathology. It is supplementary to such volumes. . . . It deals with the present-day knowledge of human physiology in so far as this can be used in a general way to advance the understanding of disease. . . . Physiology may be considered as an application of the known laws and facts of physics and chemistry."

The foregoing definition of the subject matter may be stated in other words. According to the method of treatment of the various subjects by the author, he enters first upon a simple and lucid statement of the physics and chemistry of known phenomena and then elaborates the practical application of such physiological facts to clinical medicine. An interesting and valuable attempt is made to explain the whys and wherefores of cause and effect of the underlying physiological conditions which give rise to the manifestations of health and disease.



The variety of subjects considered in the volume is too great to permit of complete enumeration. A great deal of space is devoted to metabolism and the diseases of metabolism; the chemistry of colloids is well treated in its essential details and their application to clinical medicine; the subject of endocrine disorders is considered; diabetes and insulin receive consideration, although at the time of publication of the volume the studies of insulin were still in their beginning; the central nervous system is treated at some length; the treatment of the circulation and respiration is comprehensive.

This book is written in a pleasing and simple style. Even those readers who are not thoroughly familiar with chemistry and physics will find it comparatively easy to follow the authors' lines of reasoning. The volume is one which can be read or studied with pleasure and profit by the specialist, the general practitioner, the student and the laboratory worker; it is practically indispensable to the library of those engaged in original work of almost any nature. The bibliography is sufficiently complete.

HAROLD M. BOWCOCK.

**WAR AGAINST TROPICAL DISEASE,**  
Andrew Balfour. Published for **Wellcome Bureau of Scientific Research** by **Balliere, Tindall and Cox, London, England.** Quarto, 220 pages, 180 plates and figures and 2 graphs. Price, 12 shillings, 6 pence.

This volume contains a collection of papers as well as several lectures and other chapters by the author. The subjects of the main divisions of the work are: Some Aspects of Tropical Sanitation; Tropical Problems in the New World; Preventive Inoculations Against Typhoid and Cholera; The Medical Entomology of Salonica; Sanitary and Unsanitary Makeshifts in the Eastern War Areas; The Problem of Hygiene in Egypt (three Chadwick lectures); The Palm From a Sanitary Standpoint. There is a subject index, a list of illustrations and two graphs, the latter showing the organization of the Ministry of Health and the Central Administration.

The subjects are treated in an extremely interesting and pleasing manner. The subject matter contains many accounts of the methods employed by the author in solving difficulties which he encountered; some of these are quite humorous.

Although a considerable portion of the

book is devoted to problems of particular geographical areas, the remainder of the work contains much which should be of interest and value to anyone engaged in public health work. The illustrations of tropical disease conditions, insects and sanitary appliances are very good.

Aside from the value of this book as a reference work it can be read with pleasure by anyone because of the interesting descriptions of unusual disease conditions and unusual sanitary problems and customs.

HAROLD M. BOWCOCK.

**The Treatise on the Diseases and Injuries of the Rectum, Anus and Pelvic Colon,** by **J. Rawson Pennington, M. D., F. A. C. S.,** Proctologist to **Columbus Hospital, Veterans' Hospital No. 30,** and **U. S. Marine Hospital;** Original Member and Past President **American Proctologic Society;** Fellow of the **Chicago Society of Medical History;** Corresponding Member, **Royal Society of Medicine, London (Surgical Section);** Formerly Professor of Rectal Diseases, **Chicago Polyclinic.**

This is a very complete, unique review of the diseases of the anus, rectum and colon. Due credit has been given the original statements as is evidenced by the fact that the index contains over 2000 names. This book is so written and arranged that it may be used as a text-book for the student or reference book for the physician or surgeon. Besides the first chapter, which is devoted to the historical introduction of proctology, each chapter is prefaced by a short account of the progress of our knowledge of the different affections and the means for their relief. Also, a collection of portraits of authors to whom we owe this knowledge, some of whom have probably never before appeared in print.

The book contains 933 pages, 2 plates and 677 illustrations, the original plate of the author on the frontispiece, "The Topography of Rectal and Anal Diseases," which point out the anatomical location of each disease and is named by the author as "Splanchno-Somatic Funnel," is well worth the price of the book. A mental picture of this schematic drawing would improve the

best physician in his rectal work. I highly recommend this book as a treatise on proctology. Published by the P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.

M. C. PRUITT.

**FOR STUDENTS.** A Manual of the Practice of Medicine Prepared Especially for Students by A. A. Stevens, A. M., M. D. Professor of Applied Therapeutics in the University of Pennsylvania; Visiting Physician to the Philadelphia General Hospital. Eleventh Edition Entirely Revised. W. B. Saunders Company, Philadelphia and London.

This manual has had quite a career, having made its first appearance thirty years ago. No book can have so long a life without merit. The present edition is brought well up to the standard, and while I have never felt like recommending a "Manual" to students or practitioners, it sometimes happens that a brief outline of a special subject must be had. In such an emergency, this little book will be found very convenient.

J. L. C.

**INFECTION, IMMUNITY AND INFLAMMATION** (A Study of the Phenomena of Hypersensitiveness and Tolerance, and Their Relationship to the Clinical Study, Prophylaxis, and Treatment of Disease), by Fraser B. Gurd, B. A., M. D., C. M., F. A. C. S., Montreal, Lecturer in Applied Immunology and in Surgery, McGill University. Associate Surgeon, Montreal General Hospital. Surgeon, Western Pavilion, Montreal Central Hospital. Consultant in Surgery and Surgeon in Charge St. Anne's Hospital, Department of Soldier's Civil Reestablishment. Price \$5.00. Publishers: The C. V. Mosby Company, St. Louis, Mo.

#### **MEETING OF COUNTY HEALTH COMMISSIONERS (Atlanta District)**

Contagious diseases and further preventive methods, as well as the question of registration of all births and deaths, were the main subjects of discussion at the meeting of the County Health Commissioners (Atlanta District), which was held January 30-31, 1925, at the State Capitol. Dr. C. E.

Waller, Director of County Health Work of the Georgia State Board of Health, presided. The following Health Commissioners were present:

Drs. C. L. Ridley, Macon; B. V. Elmore, Rome; J. D. Applewhite, Athens; Hugo Robinson, Albany; G. T. Crozier, Valdosta; H. B. Neagle, Augusta; O. H. Cheek, Dublin; Sam A. Anderson, Milledgeville; L. L. Welch, Marietta; H. E. Felton, Cartersville; M. A. Fort, Bainbridge; W. A. Harrison, Decatur; H. L. Akridge, Brunswick; B. D. Blackwelder, Gainesville; C. O. Rainey, Camilla; M. E. Winchester, Thomasville; C. S. Kinzer, LaGrange, and J. H. Hammond, LaFayette.

#### **NEW YORK POLYCLINIC GIVES TESTIMONIAL DINNER TO DR. K. WINFIELD NEY**

The staff of the New York Polyclinic Medical School and Hospital, the pioneer post-graduate medical organization in America, on March 7th, at the Hotel Astor, gave a brilliant testimonial dinner to Dr. K. Winfield Ney, Dean and Professor of Neuro-Surgery. The dinner was given to Dr. Ney in appreciation of his services in the re-organization of the institution, and was attended by the Trustees and 125 members of the teaching staff.

During the war, post-graduate teaching at Polyclinic was abandoned, its staff being greatly depleted by many of its members assuming military service. The Government took over the institution for the treatment of wounded soldiers, and because of lack of hospitalization facilities was unable to relinquish the institution until 1922, at which time it was returned to Dr. John A. Wyeth, its original founder.

At this time Dr. Wyeth was advanced in years and died before effecting a satisfactory re-organization. Without his leadership, the institution for the next two years passed through a rather uncertain period during which it made but little progress.

In the summer of 1924, Dr. Ney was placed in charge of Polyclinic and in a comparatively short time has succeeded in establishing a highly effectual post-graduate teaching organization. The institution is now running full capacity and plans are being made to more than double its facilities.

The New York Polyclinic passed through an experience which was not unlike that of many of the medical men of the country, who gave up their practice and entered the service. After the war, they were greatly discouraged when they returned home and realized that while in the service they had apparently lost their following, but in almost every instance, after a relatively short period they became re-established and did better than ever before.

So with the Polyclinic: After two rather discouraging years of re-organization, it has come into its own and is doing more effectual work in post-graduate teaching than at any time in its history.



### MARRIAGES

The many friends of Dr. William R. Houston will be interested to learn of his marriage to Mrs. Julia Scales Walton, which occurred in Shanghai, China, February 14, 1925. Dr. Houston had made his home in Augusta for many years but left for China about a year ago to teach in the Medical Department of the Yale College branch.

Dr. Walter E. Mobley, of Macon, and Miss Frances Johnson, of Providence, R. I., were married Sunday, February 15, 1925. The bride has been operating nurse at the Macon Hospital for the last seven years. Dr. and Mrs. Mobley, after a trip to Miami, Florida, are making their home in Macon.

### OBITUARY

Dr. Luther Park Stephens died unexpectedly March 18, 1925, at the age of 63. He was Grand Commander of the Georgia Knights Templar and had completed an inspection of the Brunswick commandery and about to board a train for Atlanta when friends who had accompanied him to the train saw him collapse and succumbed before medical assistance could be summoned. Dr. Stephens was born in Gainesville. After graduating from the Atlanta Medical College he took up his practice in Atlanta, which lasted over a period of 35 years. He was a past President of the Fulton County Medical Society, for a number of years a member of the Medical Staff of Grady Hospital and for ten years Vice-President of the Board of Education, during which time he was responsible for introducing medical examinations into the public schools of Atlanta.

Dr. Hubert Sheppard, widely known pathologist, died Sunday night, February 23, 1925, at the Wesley Memorial Hospital, Atlanta. He contracted blood poisoning when he pricked his finger during an autopsy. He received his "A. B." degree from the University of Oklahoma, his "B. S." from the University of Kansas, his "A. M." and "Ph. D." from Cornell and his "S.c. D." and "M. D." from the University of Chicago. He was a member of the Phi Chi medical fraternity and the Pi Kappa Phi literary fraternity. At the time of his death, Dr. Sheppard was Assistant Professor of pathology at Emory University and Pathologist for

Grady Hospital. He is survived by his widow, who is bacteriologist at Emory, and his parents, of Ash Flats, Ark.

Dr. Augustus J. Smith, formerly of Quitman, after an illness of five days with pneumonia, died at his new residence in St. Petersburg, Florida, March 22, 1925. His brother, Dr. Leighton Smith, of Quitman, and a member of the Brooks County Medical Society, reached him before the end came. Dr. Smith was widely known for his work in the study of the diseases of the eye, ear, nose and throat. He had practiced in Quitman until last fall when he moved to Florida. Dr. Smith is a past President of the Brooks County Medical Society.

Dr. Frank Mims, one of the recognized leaders in medicine, died at his home in Marietta, February 14, 1925, at the age of 49, following an illness of 6 days. He was born at Sylvester and was graduated from University of Georgia Medical College at Augusta. He had practiced in Marietta for the past 7 years. He is a past President and Delegate of the Cobb County Medical Society and a member and pastmaster of the Girard Lodge of Masons, Girard, Ga.

The numerous friends of Dr. Joseph H. Hines, 54 Forrest Avenue, Atlanta, regretted to learn of the death of his father, Mr. John H. Hines, of Columbus, February 15, 1925. Mr. Hines was superintendent of the Columbus Manufacturing Company. In addition to his son he is survived by his widow and two grandchildren.

Dr. James Richard Robins died at the home of his daughter, Mrs. H. D. Ivey, 18 Waverly Way, Atlanta, February 26, 1925, at the age of 85. He was graduated from Emory College in 1859 and later from the Medical College of St. Louis. He removed from Siloam, Georgia, to Atlanta last September.

### ALKALOSIS, NOT DUE TO ADMINISTRATION OF ALKALI, ASSOCIATED WITH UREMIA

Although, in a fatal case of uremia, with profuse bleeding from the gastro-intestinal tract, reported by T. R. Harrison and W. A. Perlzweig, Baltimore (Journal A. M. A., Feb. 28, 1925), the patient had not received alkali, there was clinical evidence of alkalosis. This was confirmed by the chemical findings, the pH of the plasma being 7.6. Such a condition has not been previously noted in uremia, as in all the cases with alkalosis heretofore reported, alkali had been administered. The best explanation for the alkalosis is that it was in some way dependent on the vomiting.



**ABSTRACT OF THE MINUTES OF THE  
MEETING OF THE BOARD OF TRUS-  
TEES OF THE A. M. A., HELD AT  
HEADQUARTERS, CHICAGO,  
NOV. 20-22, 1924**

(Continued from April issue)

**Postgraduate Extension Work**

The Secretary of the Association presented a plan for postgraduate extension work to be undertaken by the Association, together with an estimate of the cost of operating this plan. The Secretary was instructed by the Board of Trustees to continue his efforts to put the proposed plan into practical application at the earliest possible time.

**Association for Protection of Constitutional Rights**

A communication was presented from Dr. Warren Coleman, of the Association for the Protection of Constitutional Rights, to the Board of Trustees, inviting the American Medical Association to cooperate actively with the president of the Association for the protection of Constitutional Rights in a suit now pending to test the constitutionality of the medical restrictions of the National Prohibition Acts. The Board of Trustees instructed the General Manager to inform Dr. Coleman that the Board did not feel that the Association could at this time proceed in the prosecution of the suit now pending before United States courts.

**McCormack Memorial Tablet**

President Pusey, acting for a committee appointed by the Board at its September meeting, reported that arrangements had been made for the early installation of the McCormack Memorial Tablet, which will be placed in the Assembly Room of the building of the Association.

**World War Veterans' Act**

Section 10 of the World War Veterans' Act, providing that any veteran of any war is entitled to free medical and hospital service in government hospitals, was given careful consideration by the Board, and the proper officers of the Association were instructed to secure all necessary information concerning this act and to confer with committees on national legislation of state

medical associations with respect to its provisions.

**Automobile Insignia**

The Business Manager of the Association was instructed to proceed with plans to provide an official automobile emblem, to be sold to and used only by members of the American Medical Association.

**Plans to Increase Membership and Fellowship**

Plans for increasing membership and Fellowship in the Association were discussed by the members of the Board.

**Appropriations**

The Finance Committee reported that it was the unanimous opinion of the committee that all requests for appropriations presented at this meeting should, so far as possible, be incorporated in the budget to be submitted to the Board prior to the annual meeting in February, and that all appropriations should be acted on at that meeting.

**For Increasing Membership**

Dr. A. T. McCormack, chairman of a committee of the conference of constituent associations, appeared before the Board and presented the report of that committee to the conference. The report dealt with a definite plan to be entered into by all constituent associations for seeking the affiliation of all eligible physicians and thereby increasing the membership and Fellowship of the American Medical Association.

Dr. Olin West was elected General Manager of the Association; Dr. Morris Fishbein, Editor, and Mr. Will C. Braun, Business Manager.

The Board of Trustees adjourned at 10:45 a. m., November 22, to meet in annual session, Friday, Feb. 6, 1925—A. M. A. Bulletin.

**HYGEIA AND THE COUNTY MEDICAL SOCIETY**

Almost every county medical society is strongly feeling the urge to do something toward educating the public to a better appreciation of scientific medicine. The question often is this: "Just what can we do that will be ethical, not too expensive and still effective?"

Many societies are finding that Hygeia is in part, at least, a happy solution to this problem of educating the layman. Some appointed Hygeia extension committees. Some have made special drives for securing Hygeia subscriptions; and some have appropriated funds from their treasuries to send Hygeia to persons of intelligence and influence.

The Ida County Medical Society, Iowa, has shown what can be done to make Hygeia an influence in a county. The membership is but sixteen, yet it was voted to secure a club of one hundred subscribers to Hygeia. Let the secretary tell the results:

One member went right to work and got forty-one subscriptions. He talked to clubs and other gatherings, explaining what Hygeia was trying to do and that the club price was a bargain. The rest of us did the same to individuals and got respectively fourteen, eleven, ten, seven, six, three, three, three subscriptions, making ninety-eight, and then I insisted that the physicians who had laid down on the job subscribe for themselves, and only one refused. To get 100, I had to telephone or write the slow members two to four times each; but if you had made a lower price for a club of 200, I am sure that we could have gotten them by seeing doubly as many of our friends. Even those who were "from Missouri," when they looked over the sample copy you were so willing to send them, believed I had told the truth and they subscribed. The best of it is that they are well satisfied with Hygeia.

Polk County Society, Des Moines, is doing a telling bit of work by ordering fifty subscriptions, of eight months each, for teachers in the county. The secretary of the society is making recommendation to the state superintendent of public instruction that Hygeia be placed in all the schools of Iowa. Surely if our schools and teachers are not supplied with the right kind of health information, something should be done. The Polk County Society has done it.

These are but two instances, but they point the way. Let every society consider the possible good effect that would follow if a goodly percentage of the people were taking their health information straight

from Hygeia, instead of getting it from patent medicine advertising, cult propaganda or sensational newspaper stories.

Hygeia has not been extensively advertised, but every day new evidence of its acceptance by the American public is accumulating. From Pasadena, Calif., comes a telegram ordering fifty eight-month subscriptions to Hygeia; Dr. I. H. Goldberger's class in oral hygiene at Columbia University subscribes 100 per cent; the director of health education in the Denver public schools asks for material and sample copies of Hygeia to display at the state teachers' Association meeting; a teacher of health in an Alabama high school orders enough subscriptions so that each pupil in his class may read Hygeia each month; an industrial concern in Wisconsin orders fifty-seven Hygeia subscriptions for its employees; the Southern Pacific Railway, the Illinois Central, the Chicago and Eastern Illinois Railway and the Seaboard Airline have all ordered quantity subscriptions for Hygeia to be placed in the library cars of their crack trains.

There is no limit to the influence that Hygeia may be made to wield in your county. Why not start the ball rolling right away? The Hygeia Subscription Department, 535 N. Dearborn Street, Chicago, will be glad to correspond with the officers of any county society as to how the influence of Hygeia may be extended.—A. M. A. Bulletin.

---

### GRANULOMA INGUINALE AND SYPHILIS

The diagnosis of granuloma inguinale in the case of J. C. McRae, Atlanta, Ga. (Journal A. M. A., Feb. 14, 1925), was based on: the history of the case; the fact that the ulcer had not improved under four months' antisyphilitic treatment; the appearance of the lesion; the immediate improvement under antimony therapy, and the reactivation of the granuloma when antimony was discontinued. The diagnosis of syphilis was made, secondarily, on the appearance of the rash and sore throat, the three plus Wassermann reaction and the disappearance of all three under antisyphilitic treatment.

## STATE BOARD OF MEDICAL EXAMINERS

J. W. Palmer, M.D., President, Ailey.  
 N. Peterson, M.D., Vice-President, Tifton.  
 C. T. Nolan, M.D., Sec.-Treas., Marietta.  
 H. F. McDuffie, M.D., Atlanta.  
 O. B. Walker, M.D., Bowman.

W. C. Williams, Jr., M.D., Cochran.  
 H. G. Maxey, M.D., Maxeys.  
 A. F. White, M.D., Flovilla.  
 C. M. Paine, M.D., Atlanta.  
 B. T. Wise, M.D., Plains.

Georgia reciprocates with the states named below on the basis of a diploma only if the applicant had his diploma registered prior to December, 1894. After this date applicants who desire to get Georgia license through reciprocity are required to have stood State Board Examination. After April, 1914, applicants must not have graduated from class C colleges. Georgia does not require that applicants should have practiced one year or any other length of time in the State where they received their license before they will be eligible for reciprocity. Applicants for a certificate on the basis of reciprocity must make formal application on a blank provided by the State Board of Examiners. This blank can be secured by writing to the Secretary of this Board. The fee for reciprocity is \$50.00. The fee for certifying to Georgia License of those leaving the state for reciprocity with another state is \$10.00. The State Board examinations are held in June of each year in Atlanta and Augusta and on the second Tuesday in October of each year in Atlanta in the Legislative Hall of the State Capitol.

## STATES WITH WHICH GEORGIA RECIPROCATES

Alabama	Iowa	Minnesota	New Jersey	Texas
Arkansas	Kentucky	Mississippi	North Carolina	Utah
Colorado	Kansas	Michigan	Oklahoma	Vermont
California	Louisiana	Missouri	Pennsylvania	Virginia
Dist. of Columbia	Maine	Nebraska	South Carolina	Washington State
Indiana	Maryland	New Hampshire	Tennessee	West Virginia

## GEORGIA STATE BOARD OF HEALTH

Dr. John W. Daniel, Savannah.  
 Dr. A. D. Little, Thomasville.  
 Dr. F. D. Patterson, Cuthbert.  
 Dr. J. H. McDuffie, Vice-President, Columbus.  
 Mr. Robert F. Maddox, President, Atlanta.  
 Dr. Chas. H. Richardson, Macon.  
 Dr. A. C. Shamblin, Rome.  
 Dr. W. I. Hailey, Hartwell.  
 Dr. J. C. Verner, Commerce.

Dr. John A. Rhodes, Crawfordville.  
 Dr. J. L. Walker, Waycross.  
 Dr. M. S. Brown, Fort Valley.  
 Mr. M. L. Brittain, State Superintendent of Schools, ex-officio, Atlanta.  
 Dr. Peter F. Bahnsen, State Veterinarian, ex-officio, Atlanta.  
 Dr. T. F. Abercrombie, Secretary, ex-officio, Atlanta.

## Directors of Divisions, Georgia State Board of Health

Dr. T. F. Abercrombie, Commissioner of Health and Secretary, Atlanta.  
 Dr. Joe P. Bowdoin, Division of Venereal Disease Control and Division of Child Hygiene, Atlanta.  
 Dr. Alice Moses, Division of Child Hygiene, Atlanta.  
 Dr. C. E. Waller, Division of County Health Work, Atlanta.

T. F. Sellers, Division of Laboratories, Atlanta.  
 H. C. Woodfall, Division of Sanitary Engineering and Water Analysis, Atlanta.  
 Dr. Edson W. Glidden, Superintendent State Tuberculosis Sanatorium, Alto.  
 Dr. George H. Preston, Superintendent Georgia Training School for Mental Defectives, Gracewood.  
 Dr. M. A. Fort, Director Malaria Control, Atlanta.

## COMMISSIONERS OF HEALTH (Ellis Health Law)

Dr. Sam A. Anderson, Baldwin County, Milledgeville.  
 Dr. J. D. Applewhite, Clarke County, Athens.  
 Dr. L. L. Welch, Cobb County, Marietta.  
 Dr. J. A. Johnson, Decatur County, Bainbridge.  
 Dr. Howard E. Felton, Bartow County, Cartersville.  
 Dr. Hugo Robinson, Dougherty County, Albany.

Dr. B. V. Elmore, Floyd County, Rome.  
 Dr. H. L. Akridge, Glynn County, Brunswick.  
 Dr. B. D. Blackwelder, Hall County, Gainesville.  
 Dr. O. H. Cheek, Laurens County, Dublin.  
 Dr. J. H. Hammond, Walker County, LaFayette, Ga.

Dr. G. T. Crozier, Lowndes County, Valdosta.  
 Dr. J. W. Payne, Sumter County, Americus.  
 Dr. M. E. Winchester, Thomas County, Thomasville.  
 Dr. C. S. Kinzer, Troup County, LaGrange.  
 Dr. C. O. Rainey, Mitchell County, Camilla, Ga.



# THE JOURNAL

## OF THE

# MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL PROFESSION OF GEORGIA

PUBLISHED MONTHLY under direction of the Council

Volume XIV

Atlanta, Ga., May, 1925

No. 5

## Original Articles

### SOME FEATURES OF THE MENTAL DISEASE PROBLEM\*

Roger C. Swint, M. D.,  
Milledgeville, Ga.

The lay mind has no adequate conception of the complexity of the problems involved, nor the perfected mechanistic principles and the absolute coordination of functions operating in the human machine with a sound mind in a sound body.

Man's ingenuity has not yet perfected any mechanical triumph that can be compared in the slightest degree to the complexity and yet perfected and harmonious function of any one of the various systems or senses of the body machine, let alone the entire complex organism.

This complex and highly perfected body machine however, is subject to laws as are all things, and when the laws of nature are violated, there is a penalty, and this penalty is manifested in a disease of the body or mind or both.

Man's greatness is not determined by his physical machine alone, but by virtue of his ability for creative thinking and constructive acting. Through the operation and function of his mind he is superior to all other living animals or things, and hence master of the temporal affairs of the universe, therefore, the human mind might be said to be the greatest thing in the world, and a disordered or diseased human mind the greatest calamity that can happen to the human machine.

"Modern medicine has taught us that the condition necessary for a good mind include first the inheritance of such germ plasm from ones progenitors as will yield a brain capable of high grade development to individual and social usefulness, and secondly, the protection of that brain from injury and the submission of it to influences favorable to the development of its powers." (1)

In this connection, however, I wish to remind you of the fact that mental disease is an expression not only of the brain and nervous system, but of the entire body machine, and that soundness of the body is not altogether measured by physical strength, because the "strong and athletic individual may be very poorly adjusted." (2) In the sound body, the heart, lungs and all organs, sensory, secretory, excretory, etc., are united and timed in their functions for the welfare of the body machine and to give its productive powers opportunity for expression and to find some useful purpose for the energy manufactured.

If the lungs do not supplement and facilitate the work of the heart, if the glands of internal secretion do not assist the digestive system to perform its functions, or if the nervous system fails to coordinate all the various processes of the body, the resulting disorganization interferes with the correct functioning of the body machine.

The final test of a sound mind in a sound body is not reflected so much in feeling or thought, but in constructive action and capacity for adjustment. (2)

\*Read before the Tenth District Medical Society at Augusta, November 12, 1924.

### Brief Historical Sketch.

The approach to the mental disease problem may be said to be divided into four epochs:

The first period extends from the beginning of recorded time down to Hippocrates 400 B. C. During this period mental disease was believed to emanate from the Gods, and the insane were supposed to be inspired instruments under priestcraft.

The second epoch extends from Hippocrates to the decline of the Roman era. During this time or period there seems to have been an attempt to treat mental disorder as a disease.

The third epoch extends from the beginning of the Christian era to the end of the 18th Century. During this period the insane were believed to be possessed by evil spirits.

The fourth or modern epoch begun with that great and humane physician, Pinel of France, 1792, and extends to the present time. This might be called the enlightened and scientific era which has developed into the modern care and treatment. (3)

Great progress has been made in the method of approach to the problem during the last twenty-five years, but there is still a great deal of superstition in regard to those mentally afflicted, and this is among the educated as well as the uneducated. The public, however, I am glad to say is gradually becoming educated to the idea that an individual afflicted with mental disorder is to be regarded in the same light as one physically sick.

The present day trends and psychiatric concepts had their beginnings in a larger knowledge of the nervous system, particularly of its development and of the function of the vegetative neuromusculoglandular apparatus; in the growth of a genetic and behavioristic psychology; in the results of studies of borderline states, and finally in the rise of the psychoanalytic school. (4)

Notwithstanding the many controversies and disagreements brought about by Freud's theories and mechanistic views, he has made one of the greatest contributions to the modern study and approach to the mental disease problem.

The first hospital for mental disease was established at Jerusalem, A. D. 491. A gap then seems to have occurred until the 12th century when the "House of Grace" was opened at Bagdad.

During the middle ages many of the insane were confined in Monasteries, as the superstitious beliefs attributed their conditions to demoniacal possession.

In the U. S. A. as early as 1709, the Society of Friends at Philadelphia took steps toward the organization of a hospital for the sick and insane.

Georgia was one of the states to provide early care for her insane. Our institution, the Georgia State Sanitarium at Milledgeville, Ga., was opened for the reception of patients in October 1842. The life of Dorothea L. Dix is replete with deeds of sacrifice in the efforts she made to bring to individual and social consciousness the necessity of improving conditions in state hospitals, prisons and jails in the U. S. and other countries.

In this connection I would call your attention to the fact that a layman is responsible for the impetus or impulse given the modern Mental Hygiene movement that bids fair to yield an abundant harvest in the conservation of mental health.

### Some Points As To Etiology:

We cannot enter into a detailed discussion of the cause of mental disease, as the problem is very complex, but wish to merely call your attention to some points of practical value and of common interest. You cannot always put your finger on the straw that "broke the camel's back," as there are usually a constellation of factors operating.

Generally speaking the causes may be found to be both predisposing and exciting. The predisposing cause is found in heredity. It has been observed that mental disease will be present in one family and absent in another. It is rare, however, to find, after careful search, families entirely free from nervous or mental disease, alcoholism, epilepsy, suicide or some deviation from the normal.

It must be acknowledged, too, that there are instances where it might not be wise to talk about heredity too much, as some individuals are inclined to make their lives burdensome because of the notion that they have inherited a tendency or weakness to develop certain afflictions, and they spend a big portion of their lives in this anticipation. In a matter of so great importance, however, more attention should be paid to this feature of the problem in a practical way. We are extremely careful about pedigree and inheritance when making plans for breeding our stock or poultry, but are lax and careless, and indeed, more or less indifferent about the mating of our children in marriage.

Notwithstanding the fact that some of the present day writers and investigators are inclined to rather minimize the importance of heredity, it has long been recognized and is attested by hospital statistics that it may be a predisposing cause, but just the exact manner and conditions under which such transmission occurs have never been fully understood. It is assumed, however, that it may follow very closely the Mendelian law, from which may be formulated the following theoretical expectations: (5)

1. Both parents being neuropathic, all children will be neuropathic.

2. One parent being normal, but with hereditary taint from one grand parent, and the other parent neuropathic, half the children will be neuropathic and half normal but capable of transmitting the neuropathic makeup to their progeny.

3. One parent being normal and of pure ancestry, and the other parent neuropathic, all the children will be normal, but capable of transmitting the neuropathic makeup to their progeny.

4. Both parents being normal, but each with taint from one grand parent, one-fourth of their children will be normal, and not capable of transmitting taint to their progeny, and one-half will be normal but capable of transmitting taint, and the remaining one-fourth will be neuropathic.

5. Both parents being normal, one pure ancestry and the other taint from one grand parent, all the children will be normal, but half will be capable, and half will not be

capable of transmitting taint to their progeny.

6. Both parents being normal and of pure ancestry, all the children will be normal and not capable of transmitting taint to their progeny.

It is well to bear in mind that a child born defective may not necessarily come from parents with a germinal predisposition. The germ may be so damaged in development in utero that the descendant may be born abnormal. Such influences may be ascribed to debilitating diseases, poisons, alcohol and syphilis. (6)

In certain individuals the germ fusion seems to have an enmity and cannot result in healthy descendants. It should be also borne in mind that the otherwise healthy anticipating mother may harm her prospective offspring during gestation by lack of room in her pelvis, by traumatic occurrences and intrauterine disease so that it may come into the world abnormal, feeble-minded or psychopathic. It has not been scientifically determined what bearing mental influences of the mother has on her offspring, but in all probability sorrow and chronic grief may disturb nutrition, and psychic shock cause spasm of the uterine vessels with a resultant influence on the fetus. (6)

#### **Stress or Exciting Causes:**

The stress or exciting cause may be physical or psychic or a combination of both. Among the physical stresses might be mentioned trauma, acute and chronic physical diseases, pellagra, chronic drug and alcoholic addiction, syphilis, focal infection, arteriosclerosis, endocrine imbalance and so on.

Of the psychic stresses we might mention those factors and experiences that affect the two fundamental instincts that practically control all of our cravings and activities, viz: The instinct of self preservation, which is egoistic, and the instinct of preservation of the race which is more or less altruistic, and has reference to sex and sex problems. Every human has his breaking point, that is to say if you subject them to sufficient stress there will result mental disorder. The



amount of stress born before the breaking point depends on the stability of the nervous organization they have inherited from their ancestry.

With reference to sex and sex problems, the most severe blame is attached to self abuse, which has been said to cause all neuroses and some of the more severe or serious mental diseases. Laymen like to support this view, some physicians subscribe to it, but it is rare indeed, that we find this as a definite exciting cause, it being mostly a symptomatic condition.

Of course, self abuse or masturbation is harmful, because it is an unnatural gratification of the most instinctive impulse of mankind and can be easily over-indulged in, but our instincts are so ordered that our feelings revolt against it, and this feeling is supported by social and religious command.

Sometimes as a result of this practice ideas of sin and anxiety states appear. It may assume the proportion of an unpardonable sin, and the fear of having harmed oneself through this practice becomes the cause of many neurotic conditions, which can be improved or cured as soon as this fear is removed. Therefore, the harm resulting from self abuse is found chiefly in the effect on the psyche unless excessively indulged in, when its effect also becomes physical. (6)

Other etiological factors such as age, race, occupation, marital condition, education, etc., have their significance only in a general way. On the other hand it has been noted that on superficial observation in certain countries (South America, Australia, West Indies) that the intermingling of certain races has resulted in a tribe so capable of enjoying life and so unburdened with any sense of responsibility, that one may well ask whether or not our race constitutes the unsuccessful variety of humanity.

Let me at this point disabuse your mind of the notion that rural environment conduces to mental disease. As a matter of fact mental disorder is more prevalent in urban rather than rural environment. A study of the statistics of our own institution might lead one to the contrary opinion if he does

not look fully into the situation. Georgia is a rural state and most of her people have rural environments, hence our greatest number of admissions to the Sanitarium have rural environments.

In Georgia there is about one insane to every 600 inhabitants, whereas, in the more urban New England States, the ratio is as high as one to 150 or even lower.

I wish to also disabuse your minds of that popular fallacy that the moon in some way has some specific potency for causing mental disorder. The word lunatic had its origin from the latin word luna meaning moon, and its employment as applied to the insane is sufficiently common to indicate the general belief in this ancient doctrine.

This belief is of great antiquity, the Greek and Roman authors mention it. Hippocrates and Galen both refer to it in their writings. There are many people today who still have this superstition and fear, and take particular pains to avoid sleeping in the moonlight for fear of being moon struck.

So far as science has been able to determine, the moon rays have no occult influence either on the mind or nervous organization in any way. (3)

There is also a common belief that religion is a frequent cause of mental disease, as symptoms of a religious coloring are so often noted. So far as we have been able to find out, there is nothing in the various religious creeds that is particularly conducive to mental disease. More Baptists are admitted to our institution at Milledgeville because there are more Baptists in the State. The Methodist are next in number for the same reason.

When we consider the place that religion has held in the history of civilization and of the human race, it must be acknowledged that no other interest influences the feeling so deeply, and it may at times act as a factor in certain personalities.

The view is held generally by writers on mental disease that in countries where but little religious sense exist, individuals with mental disease have few or no religious symptoms. My personal experience has been that in the majority of cases it is a symptom

and not a cause. Religion is one of the commonest ways that certain personalities have of sublimating their conflicts, and the Supreme Being exercised great wisdom in making such possible.

### **The Scope of the Problem:**

There are today in hospitals for mental disease in the U. S. A. about 300,000 patients, and this number is gradually increasing by between eleven and twelve thousand per year. The annual cost for their care and treatment is between seven and ten hundred millions of dollars, besides the economic and social loss resulting from their disability.

Furthermore, it has been estimated that 7000 children are born in the U. S. every 24 hours, 210,000 every month. (8)

Of the 7000 daily born, a considerable number will reach manhood and womanhood, but will always remain children mentally. More than we like to think will develop some form of nervous disorder, and it is estimated that one out of every twenty-six will develop some mental disease. It has also been estimated that there are about 900,000 school children between the ages of 7 and 15 in the U. S., who are now suffering with handicaps involving the problem under discussion.

Let us consider certain psychological aspects of one of these unborn babes. While in utero it has no desires and nothing to do, not even breathe, every one of its functions are performed by its mother. After it is born it has to begin to breathe, eat, digest and eliminate for itself, but waited on by all the household and is truly omnipotent in having its every desire satisfied. As days go by and development proceeds his contact with the world becomes increasingly complex, and loving parents and others cannot forestall all of his desires and there necessarily arises the mental state of desire. Things wished for because they are not had. And as the years pass an ever increasing discrepancy takes place between desire and attainment, and if the child has not been properly raised, taught altruistic instead of selfish principles, he will soon be shipwrecked in his conflicts unless he has in-

herited a nervous organization that has a great capacity for adjustment.

How are these problems to be met? In no branch of medicine is the old adage "an ounce of prevention is worth a pound of cure" of so potent value as it is if properly applied in approaching the mental disease problem. The medical profession, nurses, the legal profession, teachers, social workers and social consciousness must be educated to the needs of the situation, and as to what the principles of mental hygiene can and is accomplishing along the line of prevention.

### **Mental Hygiene.**

The mental hygiene movement had its origin from a suggestion of Dr. Adolph Myer in 1906, but who is now director of Phipp's Psychiatric Clinic at Johns Hopkins Hospital. The impulse to the movement is due to the initiative of a layman, Clifford W. Beers, author of the "Mind That Found Itself," as a result of his efforts, the National Committee of Mental Hygiene was organized in New York City February 19, 1909.

The general purpose of this committee and its affiliated state organizations are to work for the conservation of mental health; to prevent nervous and mental disorders and mental defect; to help raise the standard of care and treatment of those suffering from any of these disorders; to secure and disseminate reliable information on these subjects, also on mental factors involved in problems related to industry, education, delinquency, dependency and the like. (1)

When one considers the large group of people who may be benefited by organized work in mental hygiene, the importance of the work and movement at once becomes apparent. The work is not only for the mentally sick and those with mental defect, but for all who through mental causes are unable to adjust themselves to their environment so as to live happy and efficient lives.

There is no royal road to learning, nor a definite formula for insuring that every individual will become healthy, wealthy and wise, but there are useful expedients, if properly utilized that will help us to pull



through many a difficult situation and give us a better chance of success.

One of the first things a person should learn to do, if a reasonable degree of success, comfort and mental health are desired, is to learn the difficult art of facing life as it is, and not as it is hoped, expected, or feared it may become.

Another good rule is to keep the physical machine in good order and running smoothly by having it gone over occasionally by some competent physician, so that abnormalities may be early detected and corrected.

The general public is gradually becoming educated to this idea and various clinics are being established with this in view.

Another requirement of good mental hygiene is we should make an intelligent effort to cultivate good mental habits because our habits condition our efficiency, but good habits are not necessarily rigid and unmodifiable, because such rigid habits may get us into all sorts of trouble. (2)

We should bear in mind the necessity of cultivating the habit of facing all critical situations squarely, and not dodge and postpone decisions relative to questions relating to self, herd and sex adjustments. If such should obtain, there is the danger of some temporary compensation being effected which sooner or later might lead to more or less complete disorganization of the personality. In conclusion we might give this admonition: **BE BORN WELL, KEEP WELL, ACT WELL.**

#### References:

- (1) Some Phases of the Mental Hygiene Movement and the Scope of the Work of the National Committee for Mental Hygiene, by L. F. Barker (Paper 1912).
- (2) Signs of Sanity—Paton—1922.
- (3) The Unguarded Mind—Chase—1918.
- (4) Textbook of Nervous and Mental Disease—White & Jelliffe.
- (5) Manual of Psychiatry—Rosanoff—1920.
- (6) Textbook of Psychiatry—Bleuler—1924.
- (7) Sanity and Insanity—Mercier—1905.
- (8) Community Responsibility in Mental Hygiene. (Paper by F. E. Williams, Mental Hygiene, 1923.)

#### Discussion on The Paper of Dr. R. C. Swint

Dr. Thomas F. Neil, Augusta: The division of insanities into functional, organic and constitutional disorders is helpful from an etiological standpoint. Psychoses from infection, exhaustion and intoxication readily

fall into the functional group. Paralytic, epileptic, sclerotic and organic diseases produce their quota of mental disturbances but by far the great majority of mental disorders happen because of hereditary or constitutional weaknesses.

turbances but by far the great majority of mental disorders happen because of hereditary or constitutional weaknesses.

We are all necessarily tainted as a result of our animal ancestry and we all give way at times to our animal instincts.

Instinctive, subconscious or emotional control fills up the stream of consciousness with obstructive complexes, which if not curbed, impedes or actually blocks rational thought.

It is not difficult to name the complexes of the other fellow, nor to name which emotion produced them, though they are disguised as prudery, hautier, bravado, intolerance, affectation, pessimism, gossiping or hysteria, nor is it difficult to see that if not recognized and controlled our complexes fill up our lives and in turn cause real life to become unreal. To put it concisely:

Poor emotional control produces complexes.

Complexes in control produce dissociation and insanity.

With individuals our efforts should be directed therefore in surplanting animal instincts with herd instincts, thereby controlling emotions, recognizing complexes, and exercising logical control. With the community this is best done through Bureaus of Mental Hygiene co-operating with courts, probation officers, social organizations, employment agencies, churches and educational instructors, to recognize and reach the defective, the backward, the constitutional inferior, and the unstable.

I am convinced that every school should have a psychiatrist and social workers, that every pupil should be card indexed and behavior faults, nervousness, backwardness or disease noted early.

The second great need in the treatment of mental disorders is after-care for the prevention of recurrent attacks. The importance of after-care was most forcibly impressed on my mind by a case which had been in one of the Illinois hospitals twelve times for Manic Depressive attacks.

The cause was traced to her home because she never had a relapse while at the hospital, and was an intelligent and helpful patient after her excitement subsided.

Her first attack came on after being deserted by her husband, who eloped with another woman, leaving her with three small



children. In the home, now usurping the patient's place, was a sister. Another sister of some business ability financed the home. Every time the patient returned from the hospital she tried to be helpful and to take her old place in the family, but all expostulated with her, thinking that work and responsibility might excite her. She was entrusted with no money. The affection and confidence of the children toward their aunt excited her jealousy. Unable to adjust to the "left out of it" situation, the patient avoided it by rising late. The family again interfered. She withstood their protests and scoldings for a time but eventually went into depression or excitement and was returned to the hospital. It was after the twelfth attack that the family were assembled and told that they were unwittingly responsible for the patient's attacks. The aunt promised to leave, the daughters promised to come to their mother with their affairs and make her their confidant, even when they did not feel like doing so. The patient was permitted to manage the home with a sufficient budget to run it and promised to return to the hospital after a two weeks' trial, providing she could be permitted to lengthen each furlough until considered safe for discharge. This after-care stopped the recurrences and is merely one example of common sense adjustment that can often be used by an understanding judge, probational officer, minister, social worker or physician, to clean up the psychopathic spots to be found in every community.

### INTERNAL SECRETION IN RHEUMATISM\*

J. B. Camp, M. D., Carrollton, Ga.

Rheumatism and the rheumatic diathesis are conditions concerning which there are numerous and widely differing views. The literature regarding the various phases of rheumatism is as extended as it is contradictory. The unsuspecting reader frequently is led into a morass of differing conceptions from which it is not always easy to extricate himself.

Some writers insist that "rheumatism," and by that they usually include the various disorders which have been classed under this name, is a manifestation of digestive trouble pure and simple; correct the digestion and the rheumatism automatically will be taken care of.

Others insist that it is essentially the result of an important mineral metabolism and assure the reader that recourse to certain inorganic neutralizing measures will quickly bring conviction regarding the correctness of this view.

Still others assert that there is a bacterial origin, not only for the obviously infective forms of rheumatism, but for all of them; and that the successful treatment of this disorder is not complete without at least the addition of procedures based upon its "undoubted microbic origin."

Much has been written regarding the relation of uric acid to the rheumatic diathesis, and opinions seem to be veering away from the statements so ably presented by a member of physiologist. Goodman, of St. Louis, aptly remarks, "The uric acid theory is at present tottering on its unstable foundations and we are growing more and more inclined to the view that not uric acid but rather disturbances of intermediary purin metabolism, are at the root of the evil."

Looking at this problem from the standpoint of an average practitioner, it is altogether probable that there is an element of truth in all the theories regarding rheumatism, and that the statements which serve as a prelude to this article are all correct to a certain degree. None can deny that rheumatism in the majority of instances exhibits as one of its most common manifestations a disturbance of metabolism, and considerable evidence is accruing to indicate that not a few of these cases have as the original basis of the trouble an obscure infective process which may never be so obvious as to direct attention to itself, but is only brought to light following the empiric use of stock vaccines given with the expectations that this unnoticed infection may be present. In such cases the diagnosis is often made by the clinical results of the empirical treatment, and it may be stated in unqualified terms that many of the rheumatic affections are of bacterial origin, even though they may show none of the typical findings of obviously infective cases.

\*Read before the Sixth District Medical Society at LaGrange, August 14, 1924.

The manifestations of the rheumatic diathesis are too frequently associated with digestive disturbances for the consistent physician to deny the intimacy of this relation, and it is not an uncommon thing for dietetic regulations, with attention to the inevitable defective elimination resulting from digestive activity, to bring about complete control of the rheumatic phenomena. Certain it is that the excessive amount of proteid which are so commonly eaten combine with other factors to bring about the metabolic chaos which is so usually called rheumatism. Parenthetically, it might be remarked, these persons are not suffering from the results of mineral excess; rather they are undergoing their torture because of a lack of the natural mineral elements—the vegetable alkalies—which the body needs, and which they could just as well have if their diet included more of such articles as potatoes, greens and cereals, and less meats.

Whether or not the initial cause is dietetics or bacterial in origin, there can be no doubt that all forms of rheumatism are evidences of essential changes in the chemistry of the body, and, this being granted, should not the regulators of metabolism be considered both in the etiology as well as in the treatment of the various forms of this disorder?

It is a well known fact that, in every disease process there are present two factors—the element causing the disturbance and those combating it. In any systemic derangement, both of these elements are found directly in the blood stream. The causative agent may be bacterial or protozoan in origin; it may be presence of toxins, foreign proteins, or protein decomposition products thrown into the blood stream by the disintegration of cells and tissues; it may be a lowered resistance of the leucocytes, or a diminished hemoglobin content; the organism and blood may be deficient in a certain salt. All therapeutic methods are designed to restore the blood to its normal condition and repel the foreign elements present. Organotherapy is the logical fulfillment of some

of the most fundamental laws governing pathological conditions. Those who deny this are unconsciously admitting that they have not kept abreast of modern thought in therapeutics.

It should be quite unnecessary to lend emphasis to the importance of the glands of internal secretion as regulators of the body. The hormones not only control but correlate these various cell activities, and their work is so closely connected with the factors which are concerned in the reaction of the body to the causes of rheumatism, as well as the attempt made to remedy this condition, that the physician who considers the relation of the internal secretory glands and their hormones to rheumatism is more likely to solve some of its mysteries than one who overlooks them entirely.

It is remarkable how close a relationship may be discovered between certain of the ductless glands and the symptoms which have come to be considered pathognomonic of rheumatism. Presuming for a moment that the various manifestations of the rheumatic diathesis are toxic in origin, is not detoxication essentially controlled by certain of the endocrine glands?

If the infective origin of rheumatism is admitted to be the most frequent or important, then we must also admit that certain of these remarkable organs are responsible for the production of the protective measures which the body automatically brings into play in infections.

If fundamental digestive disturbances are the most common basis for this condition, then it is proper to consider the relation of the alimentary hormone, secretin to this disease and where digestive insufficiencies are manifestly present, have recourse to the use of secretin as a remedy. So, whether rheumatic conditions are purely metabolic in origin, or whether they are due to micro-organism, or to digestion, we must not belittle the fact that in any event there must be a role that the internal secretory organs play which favors their prevention as well as the cure.

Under the present circumstances it would be quite difficult to consider this from the protective standpoint. Rheumatism is too insidious a disease. Its onset is of such a nature that it is not appreciated until one or more of the more definite manifestations—joint pains, immobility, swelling, etc.—brings the patient to his physician. We can, however, make good use of this information in the diagnosis and treatment of rheumatic conditions. For example: too often the orthodox treatment with salicylates or other neutralizing agents does not give the desired degree of results, or merely tides the patient over while the disturbed chemical conditions are under the influence of the drugs or measures used. After a longer or shorter time the patient has a recurrence and, unfortunately too often, it is more severe than the initial attack. In such cases the knowledge that the ductless glands may be frequently concerned in the rheumatism will enable the physician to consider the case from a slightly different angle—one which I regret to say is not accepted by the medical profession as a whole—and this new view-point may facilitate the control of future manifestations. It will also open up the possibilities of certain forms of organotherapy which, rightly applied, may materially influence the response of the organism to the other usual therapeutic procedures. Right here I wish to emphasize that organotherapy is not recommended as a specific in the treatment of rheumatic affections. Far be it from such, but as an important adjuvant and a phase worthy of consideration it deserves considerably more attention than it has previously received.

Frequently rheumatic manifestations follow thyroid atrophy due to pathological conditions or following thyroidectomy for Grave's disease, but the most important proof is the fact that the use of thyroid extract in many cases ameliorates rheumatic manifestations.

Probably the most comprehensive thyroid therapy is that of Leopold Levi, of Paris,

who reports that three hundred cases were treated under his direction during a period of eight years. This investigator, who is well known to those who have read the literature on the thyroid glands, differentiates a form of rheumatism which is due to what he terms thyroid instability. The disease is found in relatively young persons, is only slightly deforming and usually effects the smaller joints. In these cases the joint disturbances are by no means the only troubles. Occasionally there are other manifestations of functional thyroid disorders, sometimes evidently due to increased thyroid activity and other times, the majority of cases, it may be noted, the results of decreased thyroid activity.

The manner in which this form of rheumatism responds to treatment varies considerably with the associated manifestations. In the juvenile form where there is no very serious deformity, the response to treatment is good, and while the serious chronic and so called "incurable" cases do not respond as rapidly to this treatment, there is no doubt that persistent thyroid therapy causes a very decided benefit even in them.

The mechanism of the thyroid extract, in rheumatism above all others, has been considered one of the best means of enhancing cell activities and increasing the metabolic exchanges. Since the metabolism in rheumatism is much below par, any advantage that accrues from thyroid therapy might be considered as due to this salutary influence upon the cells. A scientific explanation of this may be gathered from some interesting experiments by Slosse, Professor of Physiology at the University of Brussels, who carried out a number of experiments both in the laboratory and in the clinic to connect the ductless glands, and as a result of his investigations he states that under normal circumstances the thyroid glands secrete a "deaminizing hormone" which influences the nitrogenous exchanges, and, when deficient, causes a reduction of the power of the cells throughout the whole organism to split up the albuminoid substances, especially the



muco-albuminoids, from which uric acid and other substances of the purin group are formed. Theoretically, then, the enhancement of thyroid actions should favor nitrogenous metabolism, and a large series of urinalyses made by Slosse and his associates substantiates this.

In view of the reasonableness of the attitude of the investigators whose work has just been quoted, there should be no doubt that the study of the thyroid aspect of rheumatism is well worth while. Since so many rheumatic individuals are not merely in a state of hypothyroidism, but in a general state of hypoerininism, i. e., there seems to be a general insufficiency of the ductless glandular activity as a whole, it is very proper to give some consideration to intimately associated glands as well as the thyroid, and this has been found to be very satisfactorily accomplished by applying concurrently with thyroid therapy the principle of adrenal support. It will be found that many individuals with rheumatism are not merely subnormal from a chemical standpoint, but their circulations is poor, their blood pressure is very often much lower than normal and, too, they are very easily fatigued. In other words, they are suffering from a deficient burning up of the wastes of their own physiology. To take care of this, as well as the thyroid side that has been referred to, I have found considerable advantage from the use of a stock formula Adreno-Spermin Co., which is a combination of a small dose of thyroid with a suitable dose of adrenal substance and spermin. The reason for the first need not be mentioned again; the adrenal substance is given for its circulatory and stimulating effects and for its influence upon the general tone of the body, whereas, the spermin, in addition to being a synergist to adrenal therapy has a decided dynamogenic and musculotonic effect, which is always advisable in these cases.

Bearing in mind the tendency to acidosis so common in rheumatic patients, and the fact that the consensus of clinical opinion emphasizes the importance of the alkalization, not merely in rheumatism but in all

conditions of reduced cellular activity, the principle of remineralization certainly is an advantage in conjunction with the organotherapy just outlined. The use of Citrocarbonte as a remineralization formula, in doses of two teaspoonfuls in glass of water, half hour before food, for a month and thereafter on alternate weeks, will supplement very materially the changes which we hope to make in the chemistry as a result of the recommended organotherapy, and in many instances the combination of these two formulas has made a remarkable difference in the rheumatism and its various manifestations.

The thymus is another gland which seems to be connected in some way with the joint manifestations of rheumatism, and several references have appeared in the literature in the last few years extolling the value of thymus extracts in these chronic joint conditions.

Naturally, it is far from possible always to cure rheumatism, but the first and most important beneficial change due to the thymus medications is a reduction in the pain present, and later, provided the case responds to the treatment, there is an increased mobility as well as general betterment of the nutrition and health.

It is not possible to explain why thymus medication does this and in what mysterious manner these results are brought about, but we know, at least, that in early life the thymus controls in a considerable degree the mineral metabolism, for it will be recalled that thymectomy causes a remarkable softening of the bones and an obvious disturbance of mineral metabolism. It may be, therefore, that there is a principal in thymus extract which favors the re-establishment of the disordered metabolism of calcium salts, which is undoubtedly a factor in these rheumatic cases, and that the benefit is due solely to this.

In conclusion, would say, that it is difficult definitely to state which case of rheumatism is of thyroid origin and which is not. The only way to answer this question

is empirically to administer thyroid extract and in explanation of this, let us remember the intimate relations of the ductless glands to metabolism, the undoubted connection between rheumatism metabolic disturbances and, therefore, the possibilities of organotherapy as a meritorious adjunct in the treatment.

## THE TREATMENT OF DIABETES MELLITUS\*

Harold I. Reynolds, M. D.,  
Athens, Ga.

The general principles of the treatment of diabetes mellitus based upon the pathological physiology of the disease have been clearly presented by Woodyatt (1). His work has been supported by various other observers, notably Shaffer (2). The plan here outlined is based upon the principles set forth by these two observers.

In no disease is dietetic management of such vital importance and in no disease is dietetic mismanagement so apt to result disastrously. It is up to the physician of today to acquaint himself with and learn how to apply the principles of treatment that have been established. It may be said just here that the use of iletin does not simplify matters, but rather increases the importance of a proper diet. The method to be outlined is based upon the total caloric requirement of the patient with the proper adjustment of the carbohydrate, fat, and protein.

A person at rest requires a minimum amount of food to supply heat and energy and to maintain body weight. This is expressed in terms of heat units or calories and varies with age, height, weight, and sex; and is called the basal caloric requirement or maintenance diet. This is the theoretical basal metabolism for the individual and may be calculated from charts and tables prepared by DuBois, and Aub and DuBois (3). From the DuBois chart we determine the surface area in square meters from the standard weights in kilos and the height in centimeters of the individual. (Standard weight may be found in Life Ins. tables). The sur-

face area is multiplied by the number of calories required per hour per square meter and by twenty four (No. hrs. in day). For example a patient weighs 75 kilos, is 173 cm. in height, is 63 years old, is a male. Referring to the chart we see that his surface area is 1.88 sq. meters. This multiplied by 36.5 (No. cal. req. per hr. per sq. meter) and by 24 (No. hrs. in a day) equals 1646.88 calories. To make up for loss of heat energy from turning in bed, etc., this is increased by 10% or 164.7 calories which added to 1646.88 equals 1752 calories. A more simple method, if the tables and formulae are not available, to calculate the caloric requirement is to multiply the patient's standard or actual weight in kilos by 24 if at rest and by 30 if engaged in light work.

Having determined the total number of calories required it is then necessary to know the amount in grams of protein, fat, and carbohydrate. This should be so adjusted that the relationship between potential ketogenic or fatty acid and potential anti ketogenic or glucose substances in the diet is as 1.5:1. Hannon (4) has prepared a chart from which one can determine the proper amount of protein, fat, and carbohydrate and in which the relationship of FA (fatty acid) to G (glucose) is 1.5:1, assuming the protein as 5% or 10% or 15% of the total calories. From this chart 1752 calories gives P-42, F-141.6, CH-59 gms. It is known that 0.46% of the protein and 0.9% of the fat may be converted into fatty acid, and 0.58% of the protein and 0.1 of the fat and all the carbohydrate into glucose; thus the FA or ketogenic value is  $0.46 P + 0.9 F$  and the G or antiketogenic is  $0.58 P + 0.1 F + CH$ . Substituting FA equals 19.3 plus 127.4 G equals 24.36 plus 14.6 plus 59 equals 146.7/97.5 equals 1.5/1. Instead of using the Hannon chart we may use 0.5 or 0.66 or 1.0 gm. of protein per kilo of body weight and from the formula presented by Evans (5) determine the carbohydrate—thus C equals Total calories— $8.9P + 22$ , and the fat from the formula (Woodyatt) F equals  $2C + 0.55P$ . Either method will furnish the proper ratio between the fatty acid and the glucose. This is necessary because upon

\*Read before the Eighth District Medical Society, Washinton, Ga., August 13, 1924.

a ratio higher than this 1.5:1 the patient is likely to develop a pathological ketogenesis or acidosis.

The chief disturbance in diabetes mellitus is the inability of the body to utilize carbohydrate, but a defective fat metabolism accompanies a defective glucose metabolism resulting in the accumulation of ketone bodies in the urine, blood, and tissues. In order to prevent this ketogenesis it is necessary to keep the fatty acid—glucose ratio as near 1.5:1 as possible. It has been shown that one gram of glucose effects the combustion of 1.5 to 2.5 gms. of fat. Now a high fat diet is desirable in order to provide a maximum number of calories for the patient, but experience has shown that as the ratio approaches 1.5 to 1 the acetone and diacetic acid in the urine become less and finally disappear entirely.

The amount of protein to be given is that amount which is necessary to maintain nitrogen equilibrium. Some claim that 0.5 gm. per kilo is sufficient for all body needs. Neuburge uses 0.66 gm. and Woodyatt 1.0 gm. per kilo. If 10% of the total calories is furnished by protein it will generally be found sufficient to keep the patient in nitrogen equilibrium. By nitrogen equilibrium is meant that the protein in the diet is equal to the amount of protein excreted.

The method of calculating the diabetic diet as outlined above is one that has been found workable and satisfactory in a large proportion of all cases. Patients placed on such a diet and kept on it long enough will in 80 to 90% of the cases become aglycosuric and the blood sugar will be reduced to a more normal figure. Such a diet will contain enough protein to maintain nitrogen equilibrium, will afford calorie maintenance, and the ketogenic-antiketogenic ratio will be 1.5:1.

Having placed the patient on his maintenance diet he will usually become sugar free within a few days. I may say here that I require all of my diabetics to enter the hospital for at least a week, better two weeks, and keep them in bed. Fasting blood sugar is determined and the diagnosis made certain

(by glucose tolerance tests if necessary) before treatment is instituted. If the urine does not become sugar free in a few days iletin is begun. The amount of glucose in the urine (vol. cc-24 hrs.), and the blood sugar percentage should be known before iletin is given. When the urine is sugar free the diet is increased by the addition of carbohydrate and fat, one gm. of carbohydrate to two gms. of fat. If the patient is taking iletin, this is also increased if necessary. To do moderate work a diabetic requires 40 to 50% per cent more calories than when at rest, consequently must have nearly twice as many calories in order to maintain normal body weight. Such a diet can be given in 75% of the cases without the use of iletin; while in the other 25% it will probably be necessary to use it. These figures are conservative. That iletin increases the tolerance is not yet proven. "Remarkable gains of tolerance credited to insulin are generally explained by failure to ascertain the degree of improvement that could be achieved by diet alone (6)." I call attention to this fact because I do not think one should be in too great a hurry to use iletin, at least not until the proper diet has been given a thorough trial. The point is that in at least 75% of the cases we can get results with diet alone, and the pancreatic rest afforded thereby is, in the light of present knowledge, as lasting and beneficial as that afforded by diet plus iletin.

The dosage of iletin is regulated by the amount of glucose excreted in the urine, one unit is given for every one or two grams of glucose excreted. This is at least a safe rule to follow. As to the time of administration no set rule can be laid down, but it is probably best to give it twenty minutes before the carbohydrate it is to balance. The time of administration may be said to depend upon the dosage found necessary. When only small doses (5 or ten units) are necessary it may all be given at one dose; while larger doses may be given two or three times a day. It is well to make blood sugar determinations from time to time and from three to four hours after an injection of iletin be-



cause it is then that the blood sugar is at its lowest. This is done in order to minimize the risk of an hypoglycaemic reaction. Blood sugar readings are not absolutely essential if every specimen of urine is examined and the patient knows the symptoms and treatment of hypoglycaemia.

Another phase of the treatment of diabetes is the education of the patient. He should be impressed with the fact that his main reliance is the proper diet and that an overstepping of this diet is sure to do harm. He should be provided with books on food values and taught how to work out and weigh his own diet. When dismissed from hospital he should provide himself with scales. Those to whom it is necessary to give insulin should be disabused of the very prevalent idea that it is a cure for diabetes. If proper time is given to this phase of the subject the intelligent patient will soon become interested and you will have no further trouble in the management of the case. The insulin patient should be taught the symptoms of hypoglycaemia and the treatment of this condition. These are (7):

1. Sudden and pronounced hunger, weakness, or fatigue.
2. Nervous, anxious, with loss of emotional control (crying.)
3. A feeling of tremulousness.
4. Vasomotor phenomena; pallor, flushing, profuse sweats.
5. Confusion, disorientation.
6. Coma with hypotonia and loss of deep reflexes.

The treatment is simple. From 50 to 100 cc of orange juice has an almost immediate effect in clearing up the symptoms. If the patient is unconscious a hypodermic of adrenalin 1-1000 intramuscularly followed by glucose by mouth or intravenously.

According to Joslin (8) diabetes is twenty times more common in the fat. Overnutrition is its most common antecedent, so the normal weight or less should be insisted upon. Others claim that a history of obesity is the exception except in Jews. "The reason that a Jew has diabetes is not that he is a Jew but that he is a fat Jew." Attention is called to the fact that obesity from hypo-

pituitarism does not cause the appearance of sugar in the urine and blood. The proper procedure in the obese is to calculate the diet from the individual's standard weight for age and height as compiled by various Life Insurance Companies.

Diabetes in children is much more serious than in the adult. The child requires more calories per kilo and more protein per kilo of body weight. It is essential that no trace of sugar appear in the urine at any time. This means that the young patient must adhere strictly to the prescribed treatment.

#### Conclusions.

1. The dietetic management of diabetes, with and without insulin, is emphasized.
2. A simple method of calculating the diabetic diet is presented, along with an outline of the treatment as I employ it.
3. Education of the patient and also the physician is stressed.

#### References

1. Woodyatt—Tr. Assn. Am. Phys., 1921, 36, 269.
2. Shaffer—Jour. Biol. Chem. 1921, 47, 433. 49, 449. 49, 143.
3. Aub & DuBois—Tice System Med. Vol. 1X, 113.
4. Hannon—Bull. J. H. H. 1922, 33, 128.
5. Evans—Jour. Am. Med. Sc. Vol. CLXVI, o. 1, 106.
6. Allen—Jour. Am. Med. Sc. Vol. CLXVII, No. 4, 554.
7. Status of Insulin—Jour. A. M. A. 80, 1239
8. Joslin—Jour. A. M. A. 82, 1887.

#### PRE CANCEROUS DERMATOSES\*

Jack W. Jones, M. D., Atlanta, Ga.

In choosing such a title one should probably be prepared to discuss etiology and pathology at length. Very probably some of the physicians present think that, from the purely scientific standpoint, such a word as precancerous should not be used. However, for the time being, disregarding etiology and pathology and considering malignancies purely from the clinical point of view, we see certain types of lesions so often associated with the development of malignancies, that these lesions cannot be dismissed with the word coincidence but must receive due consideration as potential malignancies.

In the discussion of the etiology of a disease about which so little is known as is the case here, and where so many opinions are held, it is only conjecture to say which group may be right and which wrong, or whether

\*Read before the Chattahoochee Valley Medical Association at Warm Springs, July 8-9, 1924.

any group may be right. Therefore, I believe the opinion of any physician, who has an understanding of pathology and clinical material with which to work, is worthy of consideration. Our medical journals are constantly giving us a mass of literature from experimental and research workers in the field of cancer. However, to the observing clinician of skin malignancies two facts continue to stand out on which we may base some conclusions as to etiology, viz: that of irritation and predisposition.

H. G. Wells, J. A. M. A., in an analysis of the literature to date concludes that the evidence obtained from man on the influence of heredity in cancer is too inaccurate to have any value, although familial tendencies cannot be dismissed. However, breeding experiments in animals have demonstrated that it is possible to breed animals which have a familial tendency to or a resistance against the occurrence of spontaneous neoplasma. These hereditary traits follow the mendelian law. Although, our statistics and data obtained from man are inconclusive at the present time, we all have had numerous cases whose family history will show a large percentage of cancer. This fact is of such frequent occurrence that given a case of suspected malignancy we all go into the family history very thoroughly, regarding any lesion with suspicion and as potential cancer where there is a great deal of cancer in the family.

Considering malignancy from the standpoint of irritation we can all recall cases too numerous to mention where irritation of a mole or from a pipe, etc., has seemed to be the starting place of cancer. Crocker, in his text book on dermatology, makes the statement with which most of us agree, that "The most potent factor as an exciting cause of cancer is long continued irritation." Engman J. Lab, Clin. Med. states, "The clinical factors which predispose the skin to cancer are (1) senility, (2) aetism, (3) chemical trauma, (4) mechanical trauma, (5) chronic inflammatory disease." The exciting cause of skin malignancies in the opinion of a large number of physicians could be expressed as follows: Chronic irritation in a

predisposed individual. Among the lesions which are more frequently seen as the starting place of cancer or so called precancerous dermatoses are the following: (1) senile keratosis, seborrheic keratosis, (2) cutaneous horns, (3) arsenical keratosis of palms and soles, (4) hypertrophies or verrucous growths, (5) moles or nevi, either pigmented or non pigmented, (6) vascular nevi, (7) leukoplakia, (8) long standing ulcers such as are caused by tuberculosis any form, syphilis or due to most any cause, (9) atrophies or cicatrices of the skin from burns, etc., (10) chronic irritation such as chimney sweeps cancer, tar or paraffin workers lesions, tobacco, etc., (11) sunlight, R-ray, radium or other radiant energy.

Senile keratoses: These lesions are seen in a large number of older people. From the standpoint of dermatology they are one of the most frequent forerunners of epithelioma. Their etiology has been variously ascribed to influence of sun or wind, irritation, and some change in sebaceous glands. I do not believe it practical to advise removal of all senile keratoses. I do believe in the removal of those in which there is a constant irritation or in those with a history of cancer in the family. If removed, it should be done thoroughly and no half way measures taken. Cutaneous horns should always be removed as there will usually be found degenerative changes taking place at the base of the horn. These, in my opinion, should be treated as epitheliomas. Arsenic given over a long period of time will produce in some cases keratoses of the palms and soles which shows a marked tendency to break down in to epithelioma.

Leukoplakia: These lesions occurring on the mucous membrane of the mouth from irritation, smokers patches, syphilis, etc., are a well recognized starting place of malignancy. Pfahler Arch. Derm. & Syph. Jan. 22, makes the statement that "Ulcers, fissures, crusts and warty growths on the underlip or corners of the mouth remaining longer than three weeks should be thoroughly treated."



**Moles:** These lesions offer us quite a problem as to the proper course to pursue. Here again, we do not find it practical to advise the removal of all moles, as practically every individual has some of these lesions present on the body. Again, we must fall back to the removal of any moles which are exposed to irritation and in those with a history of cancer in the family. The pigmented types of nevi usually degenerate into the nevo carcinoma or sarcoma and so should receive more careful consideration. I believe that when it is recognized that degeneration has occurred in a pigmented nevus, treatment is of little avail as to the ultimate outcome. The non-pigmented nevi usually degenerate into the epitheliomas. In almost any dermatological journal one can find case reports of malignancies developing in old ulcers, scars, etc. So these lesions for this reason if not for themselves should receive the proper treatment. Cancer of the lip from pipe smoking is a very common condition. The cancer of chimney sweeps has been recognized as associated with their occupation for many years. Tar or paraffin workers are very prone to cancer formation. Dr. Bloch, before the Southwest German Dermatological Congress, Oct. 1921, reported the development of carcinoma in 100% of mice-guinea pigs and rabbits by repeatedly painting the skin with a certain fraction of tar. It is a well known fact that malignancies frequently follow the occurrence of X-ray and radium burns. For this reason if for no other, one should be very careful in his estimation of dosage and application of X-ray and radium. These are by no means harmless agents.

When we attempt to discuss prevention of these lesions or advise as to treatment we are entering a larger field than one can hope to cover in a paper of this scope. So I will only touch lightly a few points in the management of some of the more prominent lesions mentioned.

**Senile keratoses:** If it is considered advisable to remove one of these lesions, I believe they should be treated as a basal cell-epithelioma; removal with a massive dose

of X-ray or radium or fulguration complete. Cutaneous horns as stated above should be considered malignant. Removal of the horn and the base should be treated with a massive dose of X-ray or radium. Leukoplakia: I wish here to condemn the practice of the use of superficial caustics in this condition. Thorough cauterization or electro-coagulation should be resorted to if any treatment is attempted. In the removal of moles I find the electric needle the method of choice when the nevus is not too large. In this way one can obtain thorough removal of the nevus with practically no scar remaining. If the lesion is too large the use of fulguration, carbon dioxid snow or radium will usually be found to give good results. In the very superficial flat type of pigmented nevi where the cosmetic result is so important trichloracetic acid, as advocated by Trimble, can be used with excellent results. Ulceration and cicatrices should, of course, receive appropriate treatment. Chimney sweeps cancer, tar and paraffin workers cancer are more a problem of industrial surgery. In X-ray or radium burns the solution lies in guarding against the giving of sufficient amount of the ray to produce atrophy, etc. I do think some progress is being made in the treatment of these burns with ultra-violet rays.

In conclusion, I would like to leave the following impressions, (1) Condemnation of the practice of the use of superficial escharotics in precancerous dermatoses or the use of any treatment where irritation will result without destruction. (2) Careful observation of all so called precancerous dermatoses. I do not believe in treating cancer conservatively if the hope of a cure is entertained. This applies to surgery, X-ray, radium or whatever agent is used. The same principle should be kept in mind in the treatment of precancerous dermatoses. We at least are blameless if after careful study and consideration we apply the well known maxim, "Do unto others as you would have them do unto you."

#### BIBLIOGRAPHY

- H. G. Wells, J. A. M. A., Sept., 22, 1923.  
 Crocker's Text Book, 1903. P. 999.  
 Engman Journal Laboratory & Clinical Med. Oct., 1915.  
 Pfahler C. F. Arch. Derm. & Syph. Jan. 1922. P. 116.  
 Bloch, Arch. Derm. & Syph. March, 1922. P. 381.



**ACUTE INTESTINAL OBSTRUCTION\***

Paul W. Best, M. D.,  
Atlanta, Ga.

Intestinal obstruction is more fraught with tragedy than any supposedly remediable condition with which the abdominal surgeon is confronted and, hence, there is no condition that has caused more intense controversial discussion. A glance at appalling mortality statistics collected from various sources strikes one with the urgency of an enlargement of knowledge of every aspect of the condition, an improvement of diagnostic ability, and an agreement upon a rational standardized treatment.

A review of the records of the colored section of Grady Hospital for the three year period ending October 1, 1924, shows a mortality rate in obstruction, excluding the cases of strangulated hernia, of 66.6 per cent, which is about the average figure from other sources. Guilleme (1) collected a series of 3269 cases with a mortality of 63.2 per cent; Ashhurst (2) collected 346 cases with a rate of 69.3 per cent; St. Thomas Hospital, London, over a period of twenty years showed a death rate of 58 per cent; while Lee (4) and Downs (14) reviewed the records of Philadelphia Hospitals and found the enormous rate of 75 per cent.

The etiology of obstruction is too well known to deserve more than passing mention. In the Grady Hospital series were included such diverse causes as hernia of various types, volvulus, intussusception, stricture of rectum, carcinoma of colon, Meckel's diverticulum, and intestinal adhesions.

The type of toxemia as well as the origin of the toxin recognized as the cause of death in obstruction has never been fully understood, and yet the knowledge on this subject is much more complete than it was a few years ago. Many diverse and interesting opinions have been advanced, most of which have proved to be theories that could not be substantiated. Gerard (5) has contended that the toxemia is due to a combined histamin normally present in the intestinal tract to which the mucosa is not

permeable unless altered by disturbance of blood supply. Koessler (6) has found a histamin in a supposedly normal ileum which when injected intravenously in dogs caused a toxemia with signs similar to those observed in obstruction; namely, spastic constriction of intestines, shocks and fall of blood pressure. Both these workers have believed that death occurred earlier in high obstruction due to more rapid absorption in the duodenum incident to greater frequency of glands there; namely, those of Lieberkuhn and Brunner. Werellus (7) has observed that in obstruction bile secretion stops before death and has suggested that liver insufficiency is a probable factor in the toxemia. He asserts that bile flow depends greatly upon peristaltic action of the intestines and that, in as much as the segment of intestine below the site of obstruction becomes a peristaltic, the higher the obstruction the larger the amount of a peristaltic intestine and the more rapid the development of liver insufficiency. Sweet (8), on the other hand, believed that the toxin was an abnormal product elaborated by an abnormal mucosa, and that the elaboration of the toxin was dependent in some way upon an altered pancreatic secretion, basing his belief on the often observed clinical similarity between the symptomatology of acute obstruction and acute pancreatitis. This theory was disproved by Ingvalden (9) who showed that the type of toxemia, in experimental obstruction in dogs, was not altered by previous removal of the pancreas.

However, whether the toxin is elaborated in the lumen or in the mucosa of the intestine is of little more than academic interest. The important point is to have information as to how it reaches the blood stream and how it reacts on body tissues. Costain (10) has conclusively shown that the bulk of the toxin is absorbed by way of the lymphatics to the thoracic duct and thence into subclavian vein. He demonstrated that in experimental obstruction in dogs, the animals would ordinarily die within five to seven days, but that if a thoracic duct fistula was established they could be kept alive for a period as long as four weeks.

\*Read before the Fulton County Medical Society, December 4, 1924.

Whipple, Haden, and Orr have been the chief contributors to our knowledge of the changes in blood chemistry occurring in obstruction and have demonstrated much of practical value. Whipple (11) has shown that the toxin is a member of the proteose group which, when released in the blood, causes an increase in the urinary secretion of no protein and urea nitrogen and a corresponding increase of the levels of these products in the blood. Haden (12) and Orr (12) have gone a step further in demonstrating a marked fall in chloride excretion in the urine and a marked reduction in the chloride content of the blood. Acting on the belief that there was an association between the fall in chlorides and the increase of non-protein nitrogen in the blood, they demonstrated, in dog and man, that administration of sufficient chloride to restore the level of blood chlorides to normal caused an abatement of toxemia accompanied by a fall in non-protein nitrogen content of blood and urine. They rightly concluded that the chlorides in some manner act as a protective agent for tissue protein against the proteolytic action of the toxin. They recommend in obstruction cases a daily dose of one gram of sodium chloride per kilo of body weight, best given in 3 per cent solution subcutaneously, a very practical point in treatment. The same workers also demonstrated that obstruction is attended by an alkalosis as indicated by increased carbon dioxide combining power of the plasma, thereby showing that administration of large doses of alkalies in obstruction is not proper.

As far as prevention of obstruction is concerned it must be admitted that aside from the cases due to unrepaired hernia, the majority of cases can not be foreseen and hence cannot be avoided. However, in the series reviewed at Grady Hospital 23 per cent of cases were due to intestinal adhesions resulting from previous operation.

One might digress here for a moment to discuss the question of abdominal drainage, for ideas as to when drainage is necessary are undergoing a change, and most opera-

tors are draining a smaller percentage of cases than formerly. It is self evident that a cavity with the ramifications and variety of topography possessed by the peritoneal cavity can at best be ineffectively drained and it is point of controversy at present as to whether drains do more harm than good in many cases in which used. Blake and others are reporting better results from less free use of drainage and there is no doubt that in the past the profession has rather too slavishly followed the ancient dictum of Lawson Tait, "When in doubt, drain." Unfortunately no definite rules can be laid down as to when to drain and when not to. Wilensky and Berg (13) have endeavored to formulate a scientific standard to settle this question by basing the decision on a rapid smear for organisms from the operative field. When few or no organisms are present drainage was dispensed with and in a series of 46 cases they report good results with this procedure as a guide. Almost as important a factor in the production of adhesions as unnecessary drainage is unnecessary operative insult of tissues, a surgical misdemeanor not so common as formerly as local anesthesia has developed greater respect for tissue and taught the surgeon greater deftness and gentleness in operating. Introduction of foreign substances, such as olive oil and paraffin, into the peritoneal cavity with the idea of preventing agglutination of raw surfaces has not been vindicated. Kubota, however, has recently suggested the use of papain solution, 1-100-000, basing the recommendation upon experiments on dogs. This harmless procedure should be used in cases where a mass of adhesions is anticipated after operation.

It is necessary to mention the symptomatology of obstruction only in so far as it affords opportunity to stress the great importance of early diagnosis. Obstruction may be divided into two stages from the standpoint of signs and symptoms. In the first stage the symptoms consist of sudden severe paroxysmal shifting pain in the abdomen, nausea followed by persistent vomiting, cessation of passage of gas and feces



after the lower segment is emptied, hyperperistalsis as elicited by stethoscope, with normal pulse, temperature and respiration. It is in this stage that the diagnosis should be made, and if a patient with these symptoms is presented in which symptoms are not ameliorated by gastric lavage and enema, exploratory incision should be made even though the diagnosis is not assured, for procrastination may be fatal. There is still a too prevalent tendency among surgeons to await pathognomonic signs, particularly in patients developing obstruction a few days after abdominal operation, and during this waiting period the patient is rapidly getting past surgical aid. At Grady Hospital the mortality in cases operated in less than 48 hours was 15 per cent. Richardson reports a mortality of 32.5 per cent in cases operated under 48 hours, 48 per cent in cases operated later than 48 hours after onset.

The operative procedure to adopt depends on a number of factors; chiefly, the condition of the patient and the duration of the condition. The longer the duration and the greater the toxemia the more conservative should be the immediate surgery. The three main considerations in operation are removal of toxic substances, relief of distension and restoration of the continuity of the bowels. These are of immediate importance in the order named; the drainage of toxic substances being by far the most immediately important in late cases, this being best done by high jejunostomy under local anesthesia. Jejunostomy should be done even in cases where the obstruction is easily relieved, serving the purpose of disposal of toxins far better than does lavage. Furthermore, when the obstruction is relieved in the absence of jejunostomy, there is a discharge of toxic substances into the collapsed paralysed distal segment which, by its condition of dehydration, favors rapid absorption that may result in early death after operation, a fact that has recently been greatly stressed by Haggard and others. That jejunostomy, and jejunostomy alone, is the proper immediate procedure is well shown in statistics collected by Guillaume

(18) which showed in 694 cases a mortality of 17.5 per cent where jejunostomy alone was done, 24.2 per cent in cases that had relief of obstruction plus jejunostomy, and 48.2 per cent in cases that had relief of obstruction alone. The type of jejunostomy best suited is similar to the Witzel gastrostomy. The Mayos (19) have improved this operation by bringing the tube to the surface through the great omentum which prevents adhesion of the intestine directly to the abdominal wall and forms an additional barrier against leakage.

Whether spinal anesthesia should be used in operating for obstruction is a debatable question. In late cases where the condition of the patient precludes other surgery than jejunostomy local anesthesia should be the choice. In early cases spinal anesthesia offers the advantage of less shock and better exposure. Furthermore, the spinal anesthesia itself often results in an evacuation and may obviate necessity of operation.

The after treatment is important. The intestine should be frequently irrigated through the jejunostomy tube. Large quantities of salt solution should be given by rectum, subcutaneously, and intravenously, because of the protective action of the chloride. Alkalies should not be given in the presence of an already existing alkalosis.

### Summary

Intestinal obstruction demands constant thoughtful consideration, due to its appallingly high mortality rate.

Obstruction may be foreseen and prevented at times by improvement in operative technique and less free use of drainage.

Early diagnosis may be expected to lower mortality by about one-half.

The toxemia can best be combated by large doses of sodium chloride. Jejunostomy is the operative procedure in late cases, and may be used as an adjunct to other measures in early cases.

### BIBLIOGRAPHY

1. Guillaume—Occlusion de L'Intestin 1922 Maury; *Annals of Surgery*, 1907.
2. Ashhurst—quoted by Lee and Downs, *Annals of Surgery*, July, 1924.
3. St. Thomas Hospital, London, Ditto.
4. Lee and Downs, *Annals of Surgery*, July, 1924, PP. 45-50.
5. Gerard—quoted by McKenna, J. A. M. A., June 9, 1923.



6. Koessler—Ditto.
7. Werelius—J. A. M. A., August 12, 1922, PP. 535-539.
8. Sweet, Pect, and Hendrix, *Annals of Surgery*, 1916, P. 721.
9. Ingvalden—*Jour. Exp. Med.*, January 1, 1925, PP. 117-127.
10. Costain—*Burg. Gym. and and Obstr.*, 1924, P. 252.
11. Whipple—J. A. M. A., 1916, 67, 15.
12. Haden and Orr—J. A. M. A., May 10, 1924, PP. 1515-1516.
13. Wilensky and Berg, *Annals of Surgery*, May, 1923, PP. 558.
14. Richardson—quoted by Sweet, *Penn. Med. Jour.*, March, 1923.
15. Haggard—*Tenn. Med. Jour.*, August, 1924, PP. 131.

### ACUTE APPENDICITIS\*

W. A. Selman, M. D.,

Atlanta, Ga.

I was prompted to present a paper on this familiar subject on account of the fact that its prevalence still holds first place among serious intra-abdominal disturbances, and its mortality is still too high.

No specific organism has been found responsible for its occurrence, therefore, no vaccine has been successful in its prevention. The incidence of so high a mortality lies not so much at the door of the physician, as that of the public itself; on account of the prevalent custom of calling a doctor only after "home remedies" have failed.

How often have we all seen patients suffering from complications of a disease, which if seen in the beginning, could have been relieved, whereas twenty-four or forty-eight hours, often hours of attempts at purgation, have been allowed to go by before calling for help. Thus acute appendicitis, usually a curable disease, is quickly followed by general peritonitis, often an incurable one.

In discussing this subject I shall confine my remarks to the four types according to Deaver's classification; the simple catarrhal, ulcerative, perforative, fulminating or gangrenous. The symptoms of these types vary so rapidly with the progress of the disease that one type today is a different one tomorrow. So a catarrhal condition may soon become ulcerative, gangrenous, ruptured, or one of spreading peritonitis, all within less time than forty-eight hours.

However, there is usually such a sequence of symptoms that so great an authority as John B. Murphy laid great stress upon the

fixed order of their appearance and any variation of this order made him seriously consider the diagnosis. This sequence of pain, nausea, vomiting, muscular rigidity, increased temperature and leucocytosis are usually spoken of as the "classical symptoms." I shall not attempt to go into a discussion of all these symptoms, which are no doubt familiar to all of you, but rather comment upon them from the standpoint of personal experience.

In regard to the primary pain, which is usually the first symptom complained of, the distress is so decidedly epigastric, that, even though there be more tenderness on the right side, the patient is often inclined to put his own judgment against that of his physician and insist on procrastination, as he is sure he only has "acute indigestion" and does not need an operation, for he has had the same thing before and recovered.

So often it is only next day that he will admit that the soreness is worse in his lower right abdomen, and that after all, maybe his physician is right, and that he is ready to take his advice. Even then all may be well unless he decides he must wait another day until some relative can arrive from a distance.

This inconstant primary pain usually begins suddenly and may soon pass for a time only to come again, but when the inflammation extends to neighboring structures, as to the peritoneum, then constant or secondary pain sets in. Should this extension be posteriorly, it often encounters the genito-crural nerve and causes pain along its distribution.

Nausea is usually present, but so often it is attributed to a dose of salts or oil taken soon after the pain began. This nausea also called primary comes in, wanes and is supposed to be a reflex through the solar plexus. A secondary nausea is set up through a decomposition of the intestinal contents so often retained by a closed ileocecal valve or paresis of the intestinal wall.

Of the third classical symptoms, tenderness, I lay more stress than upon any single sign. Pain may be indefinite or remote,

\*Read before the annual meeting of the Chattahoochee Valley Medical Association, 1924.

but pain on pressure is definite, the muscular response is involuntary, pathology is near at hand. Fever in early stages of the disease, I consider the most inconstant symptom. Just about as often as not the temperature is normal or even subnormal. I like to know what it is—but depend very little upon it for my diagnosis. After the first twenty-four hours it is more apt to be elevated. The pulse likewise is very variable at first, but increases out of proportion to the temperature as peritonitis sets in.

Blood counts are often of great value in differential diagnosis, but I am in full accord with an editorial in the *American Journal of Surgery*—January, 1924. "When, however, there are acute abdominal pains and rigidity, not produced by pneumonia, we have to deal with the so-called acute abdomen and surgical intervention is needed no matter what the blood count." A differential diagnosis of acute appendicitis from the many other abdominal affections would mean a discussion, beyond the import of this paper.

Treatment: Whatever might have been the cause, when an appendix becomes inflamed, I consider it a menace to life and too dangerous to depend upon medical measures for relief. Our larger hospital statistics show that the mortality rate is lower in direct proportion to early surgical intervention.

However, after peritonitis has set in, especially an increasing peritonitis, unrestrained by a protective wall, the mortality is high with any known method of treatment and in many large hospitals has been shown to be higher when operated upon during this stage than when treated expectantly by the Ochsner-Fowler-Murphy method for a time and operated upon after the infection has reached its height or localization has taken place. This "watchful waiting" will save many cases, but will also lose some that might have been saved by prompt surgery. Since it is impossible to know the exact pathology before operation, unless a patient is in actual shock from some abdominal condition, it has been my practice

to open the abdomen promptly and then try for the best life saving plan that seems apparent. If a localization has occurred about the appendix I insinuate a gloved finger into some line of cleavage until I find an opening into the peri-appendiceal cavity. Without trying to remove the appendix I insert two or more cigarette drains and get out with as little trauma to the peritoneum as possible. If rupture has already taken place and free pus is in the peritoneal cavity, I am still content to put in several soft cigarette drains and leave the appendix unless it be easily accessible and removable without trauma to the surrounding peritoneum. Should paresis of the bowel be present, it is quite as necessary to drain the bowel itself as it is the peritoneal cavity. This can be done by suturing a catheter into the lumen and drain through the same opening as the cigarette drain.

In decidedly septic cases the choice of an anaesthetic may mean the success of an operation. Here the emunctory organs are already over-worked and the added irritation of an ether anaesthetic might further add to the hazard, whereas a light gas oxygen anaesthetic, assisted by a novacaine infiltration of the tissues, practically no shock, and usually no nausea.

In operating I prefer the right rectus incision, retracting the muscle inward without splitting it. However, if a mass can be felt beforehand, I make an incision over the most prominent part.

Some hernia will follow drainage cases and it is no reflection upon the surgeon to have them occur. He should be congratulated upon saving the patient's life. A hernia can be repaired any time after recovery.

In conclusion I wish to remind you that over 14,000 deaths occur annually in the United States from appendicitis—that the earlier the removal of the appendix, the lower the mortality rate and lastly, as aptly expressed in an editorial in the *American Journal of Surgery*, January, 1924, confronted with an "acute abdomen," it is better to err as one sometimes must, on the safe side—to be occasionally wrong rather than right too late!

## RECTAL FEEDING

George M. Niles, M. D.,

Atlanta, Ga.

The administration of food by the rectum is a method that dates back to antiquity. Aetius and others refer to it, though not in satisfactory terms, as they probably did not obtain success on account of their imperfect technique. Voit found that a dog's rectum would not absorb egg-albumen and water unless sodium chloride was mixed with it.

Later von Leube advised the use of albumen to which chopped pancreas has been added. Ewald, however, showed that this was not necessary and that albumen neither peptonized nor pancreatinized, could be absorbed, especially if a small amount of salt was added. The presence of salt seems to cause a reverse peristalsis and Grutzner has demonstrated that substances introduced with the salt solution may later be found in the stomach.

Many varieties of food may be utilized in rectal alimentation. Protein may be supplied in the form of predigested meat or egg-albumen, to which salt has been added. Of the carbohydrates, grape-sugar seems the most available, though not more than 6 ounces of a 10 to 20 per cent solution should be allowed, as it tends to provoke looseness of the bowels. Starch has been used in many forms, solutions containing it being readily digested and absorbed. Fat also may be used, but not more than  $\frac{1}{2}$  ounce in the twenty-four hours is advisable. Such fats as cream or oil may be employed, but I prefer melted butter added to the enema. Should rectal feeding be kept up for some time, it will be best to combine different articles, as well as to change the form of administration.

Bauer believes that but one-fourth of the nutriment required by the body can be absorbed by the rectum and both he and the earlier writers placed the limit of time during which rectal feeding was practicable at two weeks. Later writers have placed the calorie absorption by the rectum even lower and it is now a fairly well-established fact

that under ordinary circumstances the rectum cannot be expected or made to digest and absorb more than 300 calories daily. Therefore, while this method of alimentation is a most useful adjunct, and is of great help in tiding a patient over an emergency, the physician should not feel that he is in any sense adequately supplying the needed daily calories.

The successful administration of nutrient enemas depends on knowledge and care. With careless or faulty technique, the food is not retained, the rectum and anus become irritated and failure is the result. In hospitals, or where a specially trained nurse is at hand, the physician may give general direction, but in the absence of these, very explicit directions are requisite.

### Method

The rectum should be cleansed well by a rather high enema of salt solution at least once daily. Cleansing before each feeding, as some recommend, is too often. Should the rectum be inflamed, a solution of boric acid may be used instead of salt solution, and if there is much stringy mucus, a solution of sodium bicarbonate, a teaspoonful to a pint of water, is helpful. If there is an inclination toward tenesmus, a return flow catheter or recurrent tube should be used for the cleansing enema. The temperature of the cleansing enema may be as hot as 95° to 105° F., but the nutrient enema should be strictly between 90° and 95° F., as solutions too hot or cold are promptly rejected.

Unless prevented by some condition of the disease the patient should lie on the left side with his hips well elevated. A rectal tube or large catheter may be employed, not too large, though, a tube about 16 or 18 English is proper, smaller ones being needed for children. The tube should be well lubricated, but not with glycerine.

As the tube is introduced, it should be rotated slightly, and if any folds of the rectum impede its progress, a little fluid should be allowed to flow. This will "balloon" the rectum and allow the tube to advance easily 8 or 10 inches, or even more.



It is well for the tube to ascend as high in the rectum as is practicable but if efforts are put forth to carry it too high, the tube is liable to double up on itself in the distended rectum and the inflowing current, instead of pointing up, will point down.

The enema should be allowed to flow in slowly from a funnel or fountain. The former Davidson syringe, in which the fluid was sent in by intermittent jets, did not give satisfaction. Air should not be injected with the fluid. Should the patient complain of a desire to evacuate the bowel, the flow should be discontinued until the desire abates, and then slowly resumed. By tact and patience the enema may be injected with perfect comfort generally, but if the nurse is hurried or the patient fretted the fluid will in all probability be ejected in a short while.

After the injection, the patient should lie as quietly as possible for an hour or more, and be instructed to use every effort to retain the enema. A pad or towel may be pressed over the anus for about twenty minutes, and in the meanwhile, if the nurse will divert the patient's mind from his rectum, the uncomfortable sensations of fullness there will soon cease. If the rectum is very irritable, the nutrient enema may be proceeded by a small suppository of opium and belladonna, or a very small rectal injection of warm starch water containing about fifteen drops of the tincture of opium. The frequent use of opium, however, is to be depreciated. Should hemorrhoids complicate the situation, they may be painted with a 2 per cent cocaine solution previous to introducing the tube and a soothing ointment may be applied between times.

The amount given at each injection is important and should be regulated with judgment. As a rule it is not well to exceed 8 ounces, 6 are generally better. Should this be retained with difficulty, a smaller amount should be used.

The interval of time between enemas, and the number daily will depend on the condition of the rectum. For a few times it is

feasible to administer nutrient enemata four hours apart but it is seldom that a rectum will bear them long unless about six hours are allowed to elapse between. About four times daily will be generally found the limit, if this method of feeding has to be kept up for an extended period.

**INDICATIONS FOR NUTRIENT ENEMATA.**—(1) In extremely weakened conditions, as in fevers or other exhausting diseases.

(2) In obstruction of the pharynx or esophagus, where the patient is unable to swallow food.

(3) In organic diseases of the stomach (malignant or non-malignant), where it is desired to give that organ a complete rest. Also, though rarely, in severe vomiting from irritable stomach, of nervous origin.

(4) In delirious, comatose, or insane persons, where it is impracticable to feed through the mouth.

#### RECIPES FOR NUTRIENT ENEMATA

##### Egg and Milk Enema

Eight ounces sweet milk .....	170 Calories
Three eggs .....	200 Calories
Half teaspoonful of salt .....	
	<hr/> 370 Calories

##### Starch and Milk Enema

About two ounces starch .....	250 Calories
Eight ounces sweet milk .....	170 Calories
	<hr/> 420 Calories

##### Sugar and Milk Enema

Two ounces grape-sugar .....	246 Calories
Eight ounces sweet milk .....	170 Calories
	<hr/> 416 Calories

##### Von Leube's Milk and Peptone Enema

Eight ounces sweet milk .....	170 Calories
Two ounces peptone .....	100 Calories
	<hr/> 270 Calories

##### Singer's Nutrient Enema

Four ounces sweet milk.	
Four ounces wine.	
Yolk of two eggs.	
Half teaspoonful salt.	
One teaspoonful Witte's peptone.	

In addition, the enemata may be thickened with a little mucilage, or a few drops of tincture of opium may be added. Should the rectum be extremely sensitive, the enema may consist of plain warm water, to which is added the albumen of two or three eggs.

It is the custom to add to these enemata various predigested foods, alcoholic or otherwise, and they seem to be borne quite well, though their supportive value is problematical.

These suggestions fairly cover the subject of rectal alimentation, and represent the experiences of the writer over a period of many years. Such alimentation is entitled to its proper place, but many good men make the mistake of expecting too much from its use. At the best, it is a "make-shift" and the intelligent physician will recognize it as such.

### THE EYE SYMPTOMS OF CONSTITUTIONAL DISTURBANCES\*

J. R. Simpson, M. D.,  
Gainesville, Ga.

The eye manifestations of constitutional diseases and of the nervous system have long occupied a conspicuous place in diagnosis and are of great importance to all of us in our daily examinations.

I shall first attempt to give you the important points of eye manifestations in nervous disorders (according to Drs. Fuchs, Holden, and others) and then briefly describe the eye symptoms of headache, brain tumors, arterio-sclerosis, meningitis, vertigo, nausea, nephritis, diabetes, and syphilis.

In the diagnosis of nervous disorders the neurologist bases his conclusions principally on reflexes, and the ones of especial importance are eye reflexes or symptoms, because of the close relation existing between the eye and brain.

The retina and optic nerve are the visible outgrowths or portions of the lobes of the brain, and since this is true, we can readily realize how the early manifestations of brain disorders may reveal themselves through the medium of the eye, and upon examining the eye, we are able to recognize brain diseases in their incipiency, and this may be the only means we have of an early diagnosis before the disease has progressed to a point beyond repair.

The principal points to look for, then, in eye manifestations of brain disease are the

following; 1. Visual acuity, 2. Field of vision, 3. Sensibility of the Cornea, 4. Shape, size and reaction of the pupils, 5. Paralysis or abnormalities of the ocular muscles. Heterotropia or squint, 6. Nystagmus, 7. Exophthalmos, 8. Ptosis, 9. Muscular paralysis of convergence and divergence, 10. Ophthalmic examination of the fundi with regard to optic atrophy, oedema, and alterations of the blood vessels.

Corneal sensibility is best ascertained by gently touching the cornea with a piece of cotton, which readily elicits any loss of function in the ophthalmic division of the fifth nerve. If sensibility is diminished or lost and is unilateral we may suspect tumor of the cerebellum on the same side; and if so, we should look for nystagmus and unstable gait. The next important step is to ascertain if there is any irregularity in size and reaction of the pupils. Pupillary contractions takes place through the third nerve and dilatation through the sympathetic system. Paralysis of the extrinsic eye muscles is a manifestation of a disease in the nervous system, namely, tabes, multiple sclerosis, syphilis, migraine and intestinal toxemia, and this is so important that we cannot afford to overlook this phase of the examination.

The next important step in this examination is the ophthalmoscopic picture of the fundus, which will tell us if there is optic atrophy, oedema or any alterations of the retina and blood vessels. This is best done under a mydriatic; personally I do this without a mydriatic but if I find the pupils too small I use cocain because the effect wears off in a short time.

Scintillating scotoma, or (hemianopsia) is a rather common condition, although it is not a true neurological manifestation of any brain disease, yet it is of such frequent occurrence that a few words on the subject may be of interest. The condition is characterized by a feeling of vertigo. Sparkling lights appear before the eyes, which rapidly increase until it is impossible to read or see objects clearly, and the field of vision is contracted. The condition will last from one-quarter to one-half an hour, after which

\*Read at the 9th District Meeting, Sept., 17, 1924.

it abates and the vision returns to its normal condition without leaving any bad effects.

The etiology of this is a blood stasis of the brain which is probably situated in the optic areas of the cortex of the occipital lobe. The cause of these attacks may be due to refractive errors but its most frequent cause, however, is due to some constitutional disturbance, such as constipation and gastro-intestinal toxemia, or some focal infection in the accessory sinuses or teeth. If the attacks are frequently repeated I would suggest small doses of quinine to be taken for some time, in addition to the systemic treatment that may be necessary. So much for the neurological phase of the subject, and we will now consider the essential points of the constitutional conditions above enumerated.

Headaches; this is a very common trouble and may be due to various causes, but we are only concerned in the eye headaches. This may be due to refractive errors, heterophoria, glaucoma, iritis and brain tumor. Now how do we determine which one of these conditions may be the cause of headache? We must do so by the process of elimination. However, let us briefly consider each phase. Headaches due to refractive errors are usually manifested in the eye ball, frontal and occipital regions, which generally disappear upon closing the eyes and during sleep. The usual test for vision that may cause headache does not mean very much to the general practitioner unless he is familiar with the different refractive errors because a very defective vision will not cause headache as a rule, while apparently normal vision may produce violent headache for the reason that the eyes or nature cannot overcome a large defect, and therefore the eyes are at rest, while in the small refractive errors nature can and does correct, and it is this constant strain that produces headaches.

Heterophoria is a muscular imbalance of the extrinsic ocular muscles; i. e., there is tendency of the eyes to deviate from the parallel line with relation to the other, especially when looking in a certain direction, and the continual effort on the part

of nature to stimulate or strain the weak muscles to maintain a parallel position of the eye balls or single vision will produce more headache than was formerly supposed, especially in children of school age. Now, how do we determine this without a technical procedure?

This may be done in the following simple way. Have a patient's head in a fixed position and then direct him to look at the point of a pencil which is moved in all meridians. If there is muscular equilibrium (orthopora) the eye will remain parallel in all of its meridians. If there is a deficiency you will note a slight deviation from the parallel line in some meridians.

Glaucoma; this is characterized by disturbance of sight or hazy vision which often gives a color halo or ring about a light. There may or may not be inflammation; sometime the eye ball has the appearance of a white marble. The pupils are generally dilated, and headache accompanied with nausea and vomiting is a prominent symptom. The most reliable test outside of the tonometer is the digital palpation of the ball with the two index fingers. Of course, to determine whether or not there is an increased tension in this way, you must be familiar with the digital touch or palpation of a normal eye ball. The gravity of this disease is familiar to you all and will need no further explanation, except that it may be well to caution you to never, under any circumstances, use a mydriatic in this condition. This is often done because of a mistaken diagnosis of glaucoma for iritis.

Iritis is another element of headache and this is determined by pain, photophobia, hazy cornea, inflammation and the iris is usually discolored or greenish in character and the pupils are generally contracted. This is another serious condition and often compounded with glaucoma. Here again is a condition where we must use a mydriatic and not a myotic.

Brain Tumor; in this condition the ophthalmoscopic examination will reveal choked disk—that is, the papilla is swollen or raised considerably above the level of the retina, and the oedema is striated radially. The



veins are engorged and arteries narrow or smaller. Choked disk is present in about 80 per cent of brain tumors and is more often found in the cerebellum. Since brain tumors are quite common and usually first manifested in the eye grounds, it behooves us to examine the funds in every suspected case, or of those who have persistent headaches.

Vertigo is a condition which may be due to eyestrain, glaucoma, heterophoria and nystagmus, all of which have been explained, except nystagmus. This is a big subject and one which would require more time than is available at this discussion. However, since it is a very important element in diagnosis, I will give a few essential points for consideration.

Nystagmus is usually divided into two special types—namely, ocular nystagmus and vestibular nystagmus. Ocular nystagmus has a special character in which both movements of the eyes occur with equal rapidity and amplitude of excursion, and is never rotary. I am sure all of you have seen this form of nystagmus in the albino.

Vestibular nystagmus is distinguished from ocular nystagmus by rhythmical movements of unequal velocity, or has two components, quick in one direction and slow in the other, and is the one in which we are mostly concerned. It is usually designated by the quick component. Nystagmus may be produced by various conditions, as alcohol, tobacco, intestinal intoxication, seasickness, brain abscess and tumor, meningitis, fracture of the skull, mastoiditis and labyrinthine disease.

In spontaneous nystagmus, which is always pathological, the rotary element is usually present with nystagmus in another plane. The quick component is toward the diseased side or ear, unless the labyrinth is diseased or destroyed, and when it is the quick component is to the sound side for a few days, and then after that it subsides. But if it returns to the disease side meningitis is present on the diseased side.

The presence of nystagmus may be easily overlooked, unless you have the patient look to the extreme right or left.

Nausea may be due to brain lesions, heterophoria, blaucoma, eyestrain, etc., and if due to any of these conditions, they can be easily determined as I have already outlined in a brief way.

Arterio-sclerosis is another condition which can be revealed by ophthalmoscopic examination, and perhaps earlier than is possible by any other method.

In this condition you will note tortuosity of the small arterial twigs, or so-called corkscrew vessels. The calibre of the vessels are irregular; arteries are contracted; there may be hyperemia of the nerve head; veins are flattened or indurated where the arteries cross them. Sometimes you may note hemorrhages into the retina, and if so, this is of prognostic import, since cerebral apoplexy usually follows in about 50 per cent of the cases.

Meningitis; here we may find inflammation of the optic nerve, strabismus, ptosis, anesthesia of the cornea, pupils at first are contracted and subsequently dilated and may be unequal.

Nephritis does not reveal any special external manifestation, but does give us definite information upon ophthalmoscopic examination of the fundus. The appearance of the fundus may simulate brain tumor in the fact that we sometimes find the papillae swollen. However, the chief diagnostic difference is the white or yellowish spots in the retina, hemorrhages and blurring of the optic disc margins. The white spots may coalesce into large irregular patches and often radiating white lines appear around the fovea centralis. Vision is impaired according to the extent of the disease.

Diabetes; This is characterized by small brilliant white spots in the retina, which chiefly occupy the region of the macula lutea, without stellate arrangement, as is found in albuminuric retinitis. Usually between the white patches punctate hemorrhages are seen. Syphilis, as you know, is a very common disease and one which is capable of producing many varied conditions in the domain of pathology and is frequently the cause of headache, retinitis,

iritis, choroiditis, etc., and when we have to deal with these conditions we should look for ophthalmoscopic evidences of syphilis, which is characterized by a cloudy retina and faintly gray color in the early stage. Later on in the disease we will find an absence of the cloudy appearance and a change in the pigment epithelium. At first there will appear a clumping of black pigment and white spots which is finally transformed into a bluish white scar tissue surrounded by a black ring, and these are more often found in the anterior portions of the eye ground.

These, in brief, are the essential eye manifestations of the above diseases for your consideration, and in enumerating them it has been my purpose to refrain from giving you a technical diagnosis or the use and advantage of expensive instruments, because I fully realize the busy practitioner has neither the time nor the apparatus for this phase of examination; but if I have succeeded in giving you the prominent points that will aid you in your daily diagnoses I shall feel fully repaid for my time and trouble in presenting this paper.

References: Fuchs, on the eye. Chicago Monthly, on the eye.

## REMARKS ON DISEASES OF THE PROSTATE

J. T. Stukes, M. D.,  
Americus, Ga.

My remarks shall be confined to those conditions of the prostate which by necessity of situation we as general practitioners are called upon to treat either temporarily or over a more or less extended period.

Acute infections of the prostate are practically all gonococcal. The spongy prostate is readily invaded and this infection occurs in seventy-five per cent of all cases of gonorrhea. In some the infection is mild giving rise to so few symptoms as to be negligible and apparent cure results.

In acute posterior infection with a second or a second and third glass cloudy and on urination pain, frequency, hesitancy, dribbling and if the vera montanum is congested

bleeding upon completion of the act. Many of these acute cases terminate in abscess which ruptures in the urethra and sometimes in the rectum.

The very important consideration with us is the blood infection that may occur producing endocarditis, vegetations on the myocardium and permanent valve lesions. With this condition we frequently have infection of joints terminating in resolution or suppuration and ankylosis. Unfortunately modern therapy seems but little or no more effective than the old method. I have recently tried intravenous injection of large doses of acriflavin. My enthusiasm over this method was rather short lived, although this mode of attack by injection of acriflavin or mercurochrome may yet be successful as it seems to be on a logical basis. For when the infection extends into the testicle the injection of about thirty grains of iodide of soda in a vein is in many cases effective. As to gonococcus vaccine and other proteins we have our opinions, most of us have had our disappointments and a discussion of this subject would hardly prove interesting.

Never massage an acute prostate and in the massage of a chronic prostate some have an imaginary benefit, some have a real benefit. The important question is how much force should we use. Pain is an important guide, we should be mindful that some patients will scream if you touch them while other patients will endure exhausting pain without complaint, so the doctor had better ascertain the temperament he is dealing with. My conclusion is that pressure on the chronic infected prostate should be steady, forceful pressure up to five or six pounds, this may be necessary to express retained pathological material. One might do harm by using force against a hard nodular cancerous prostate or force against sealed up purulent material.

Even with experience there must be some guess work. Distinguishing a normal from an abnormal prostate is often a difficult matter. The normal prostate is not of uniform size; it may be small and soft or large and elastic unless one has studied the normal

and the pathological prostate and extended experience over many cases he can not acquire much knowledge of the prostate. There may be great difficulty in differentiating vesicle infection from a prostate infection. The hard or hard and shotty condition indicates infection. In old infection the second glass may be clear; this means there is no drainage from the prostate and the urethral infection has cleared up. With saline or boric solution in the bladder and forcible pressure made on the prostate, mucopurulent material may be expressed, whereas, in the next case which apparently presents a parallel condition there may be no material expressed by massage.

The hard points are only connective tissues remaining in infected foci. It is interesting to check up ones mistakes as to the prostate. Recently I massaged a prostate several times without any effect but gradually increased force until I expressed a great quantity of purulent mucus, the patient being materially benefited. When prostate seems to be bulging and massage with force is painful and there is no discharge I cover this bulging area with palmar surface of the finger and gradually increase pressure and then roll the finger.

In all cases of importance we should look not only for stricture but also examine the prostate and vesicles. In obstruction at bladder neck one should not forget to look for symptoms of locomotor ataxia, then for local cause. An acute inflammation, congestion and swelling of prostate causing acute obstruction with profuse hemorrhage upon catheterization is a condition not uncommon to the general practitioner. One should not hesitate to tap the bladder, inserting trocar about one inch above pubic bone and at an angle with point toward bifurcation of aorta. Tack the cannula to the skin and use a cork from a hypodermic vial to plug outlet.

We should not traumatize our patients by futile attempts to use the catheter. In majority of cases whether benign or malignant the swelling will have subsided in three or four days after suprapubic drainage. Dr.

Ward, of Cordele, states that adrenalin gently deposited through a catheter into the prostatic urethra will check hemorrhage and permit use of the catheter.

Another problem confronting us right frequently involves the question as to use of the catheter.

So-called hypertrophy of the prostate presents first the stage of congestion, then partial retention and later complete retention. In partial retention a residual urine may reach four ounces without infection of the bladder or uremia and the only symptom is frequency of urination. These cases should not be catheterized, but if residual urine is not more than two ounces and the bladder is infected, uremia may or may not be present. Here active treatment is indicated; citrate of potash, sandal oil or hexamethylenamine by mouth or in acute and grave conditions the latter drug by vein. Bladder should be irrigated and I have recently found that five grains of mercurochrome dissolved in two ounces of water left in bladder after irrigation and repeated daily often is effective.

It seems that in many ways Providence has rewarded the temperate and protected the innocent but not so in the case of the prostate for this gland scarred from an old gonorrheal infection is less apt to undergo hypertrophy. However, the grave consequences of a gonococcus infection many times offset this only possible and unexplained benefit.

#### AUGUST VON WASSERMANN

##### By the United States Public Health Service

The death of Professor August Von Wassermann on March 16, 1925, has deprived the medical world of one of its ablest investigators and the human race of a benefactor. Through his continued studies he has made several lasting contributions to the body of knowledge basic to general race betterment.

Wassermann was born February 21, 1866, at Bamberg, Bavaria. His father was a royal banker who gave his son the opportunity to gain a sound general and professional education. Wassermann studied med-



icine at the universities of Erlangen, Munich, Vienna and Strassburg, receiving his degree from the last named institution in 1888. He then became assistant for infectious diseases at the Koch Institute of the Charite at Berlin, gaining the title of professor in 1898. In 1901 Wassermann was given an appointment to the University of Berlin as Professor Extra-Ordinary (Privatdozent), a position carrying with it no emoluments outside of the opportunity to teach and experiment in the university medical school and its laboratories. Within a year his unselfish devotion and keen interest in the science of medicine brought him a full professorship. In 1906 he assumed the duties as head of the Division for Experimental Therapy and Serum Research at the Royal Institute for Infectious Diseases at Berlin. In 1913 he added to his duties those of director of the newly founded Kaiser Wilhelm Institute at Dahlem, near Berlin, an institute for experimental therapeutics.

As a mark of appreciation of beneficial public service the title of Secret Councillor (Geheimrat) was conferred upon Wassermann in 1907; he was also awarded the Japanese Order of the Holy Treasury, the Turkish Order of Ozman, the Spanish Order of Elizabeth the Catholic, and the Reichs Adler Order.

Professor Wassermann was a prolific contributor to medical literature. As an introduction to Ebstein and Schwalbe's Handbook of Practical Medicine he has written an able discussion concerning general studies on infectious diseases, especially influenza. He was also a regular contributor to the Eulenburg Encyclopedia, writing on immunity and serum therapy. He published many articles on newer subjects, such as hemolysin and precipitin. His best known works are contained in the Handbook of Pathological Microorganisms, which he published in collaboration with Kolle.

Wassermann made a far reaching and important contribution to forensic medicine by "his precipitin reaction which dis-

tinguishes the blood of men and animals by differentiating albumin bodies contained therein."

His greatest discovery, the complement fixation test in syphilis, was announced in 1906. This, the so-called "Wassermann Test," is an application to syphilis of a general reaction discovered by Bordet and Gengou.

An appreciation of the vast importance of the use of the Wassermann test as an aid in the diagnosis and treatment of syphilis may be gleaned from data collected and compiled by the Division of Venereal Diseases of the United States Public Health Service. The 165 laboratories of State Health Departments and State Institutions, scattered throughout every state in the Union and included in this investigation, administered 990,130 Wassermann tests in 1923. This figure, when reduced to more evident terms, means that these 165 state laboratories have given one Wassermann test per every 106 people in the United States. The importance of the Wassermann test is further enhanced by the fact that these figures do not include many Wassermann tests made by private laboratories.

Though Wassermann's name has been connected with important researches dealing with the problems of cancer and tuberculosis, he has enshrined his name in medical annals by virtue of his work in the diagnosis and treatment of syphilis. Wassermann, a distinguished pupil of Koch and Ehrlich, has earned the name of a great benefactor of humanity.

## BOOK REVIEWS

### ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1924

Cloth. Price, postpaid \$1.00. Pp. 82. Chicago: American Medical Association, 1925.

This volume contains the reports of the Council on Pharmacy and Chemistry that have been adopted and authorized for publication during 1924. Some of these re-

ports have appeared in The Journal of the American Medical Association. Others are now published for the first time.

The annual volumes of the "Council Reports" may be looked on as the companion volumes to New and Nonofficial Remedies. While the latter contains the medicinal preparations that are found acceptable, the reports contain the reasons why certain products were not accepted. Thus the present volume contains reports on the following products which the Council denied admission to New and Nonofficial Remedies: Aolan; Aspatol; Atussin, Peptoproteasi, Paraganglina Vassale, Fosfoplasmina, Asmoganglina and Endo-Ovarina Tablets; Borosodine; Carsinol, Colodine and Colobromidine; Ferrasin; Glyeuthymenol; Hoyt's Gluten Flakes; Iodeol; Loefflund's Food Maltose; Mistura Creosote Comp. (Killgore's and Tablets Cascara Comp. (Killgore's); Neo-Riodine; Nicomors; Peptone Solution for Hypodermatic Use (Armour); Pixalbol; "P-O-4"; Pollantin; Promonta; Pruritus Vaccine Treatment-Lederle (Montague Method); Restor-Vin; Some "Mixed" Vaccines of G. H. Sherman and Ter-sul Hiller.

The volume also contains reports on products which were included in former editions of New and Nonofficial Remedies but which will not appear in the 1925 edition because they were found ineligible for further recognition. Among these are polyvalent antipneumococcic serum, colon bacillus vaccine, gonococcus serum and gonococcus vaccine.

The volume contains a number of reports of a general nature: for instance a report on the therapeutic value of benzyl benzoate; a report on anaphylaxis produced by thromboplastic substances and a report on the therapeutic use of digitalis.

Physicians who keep fully informed in regard to the value of proprietary remedies will wish to own this book.

#### BOOKS RECEIVED

**Feeding, Diet and the General Care of Children**—By Albert J. Bell, M. D., A. B.,

Assistant Professor in the Medical Department of the University of Cincinnati; Attending Pediatrician to the Cincinnati General Hospital, the Tuberculosis Hospital and the Christ Hospital; Member of the Medical Milk Commission, and Chairman of the Divisional Council on Child Hygiene, Cincinnati, etc. Illustrated. Second Edition. Price \$2.00 net. Publishers: F. A. Davis Company, Philadelphia.

**Medical Education** — A Comparative Study, by Abraham Flexner. Forwarded for review with the compliments of the General Education Board. Publishers: The Macmillan Company, New York.

**Recovery Record for Use in Tuberculosis**, 2nd Edition, by Gerald B. Webb and Charles T. Ryder. Price \$2.00. Publishers: Paul B. Hoeber, Inc., 69 East 59th Street, New York City.

#### WINNERS OF MODERN HOSPITAL'S ESSAY CONTEST ANNOUNCED

Mr. Edward A. Fitzpatrick, dean of the graduate college and educational director of the hospital college of Marquette University, Milwaukee, Wis., received first prize in The Modern Hospital Publishing Company's essay contest on "The Interrelationships of Hospital and Community," which closed November 1. Three awards of \$350, \$150, and \$100, and three honorable mentions were made.

Second and third prizes went to Dr. Lucius R. Wilson, assistant superintendent, Barnes Hospital, St. Louis, Mo., and to Dr. D. L. Richardson, superintendent, Providence City Hospital, Providence, R. I., respectively.

Honorable mention was given to Mr. John R. Howard, Jr., superintendent, New York Nursery and Child's Hospital, New York; Mr. H. J. Southmayd, assistant superintendent, Mount Sinai Hospital, Cleveland, Ohio; and Miss Zella Nicolas, R. N., a graduate of the nursing school, Mount Sinai Hospital, New York, N. Y., now a student at Teachers College, Columbia University, New York, N. Y.

# THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Dedicated to the Welfare of the Medical Profession of Georgia.

65 Forrest Ave., Atlanta, Ga.

MAY, 1925

ALLEN H. BUNCE, M. D., Editor  
 M. C. PRUITT, M. D., Business Manager  
 Publication Committee  
 CHAS. USHER, M. D.  
 S. J. LEWIS, M. D.  
 T. C. THOMPSON, M. D.

Articles are accepted for publication on condition that they are contributed solely to this Journal.

Manuscripts should be typewritten, double-spaced, and the original (not the carbon copy) submitted. Used manuscript is not returned unless requested.

Communications and items of general interest to the profession are invited from all parts of the State. We especially invite county society secretaries to send us information of happenings in the county that would be of interest to the members throughout the State.

## Editorial Department

### PRESIDENT ELROD

At noon on May fifteenth our President Dr. J. O. Elrod, of Forsyth, completes his term of office. It is but fitting that one who is in a position to know of his faithful, conscientious and untiring efforts in behalf of the Association should, at this time, acquaint our entire membership with his work.

During his service as Councillor for the Sixth District, Dr. Elrod made a systematic survey of all practitioners in his District, obtaining his information direct from the tax collectors in each county. This he kept up to date by checking it with the Association and the A. M. A. records. Immediately after his election as President, he began this systematic survey of the entire State. Maps were drawn of the counties composing each Congressional District and lists of all legally qualified physicians obtained direct from the county tax collectors. This has entailed an enormous amount of work but has proved an invaluable aid to the Association and will be made a part of its permanent records.

He has written hundreds of letters direct

to individual members in reference to keeping up their membership. These have always been preceded by letters to the secretaries of the respective county societies. He has not only made a strenuous effort to keep all members active but has also exerted every effort to bring into the organization every eligible physician in the State.

As he has traveled up and down the State and across it, the keynote of every talk has been organization. Every speech has been introduced with a few remarks on organization; the body of each address has been on organization; the conclusions have always been a summary of the practical methods of organization; and each discussion has been closed by the remark, "pardon my insistence, but organization is my motto and hobby."

If we had an Elrod in every county in the State our organization would be 99 44-100 per cent perfect.

A. H. B.

### THE ANNUAL MEETING

The seventy-sixth annual meeting of the Association, which will be held at the Atlanta-Biltmore, Atlanta, May 13th, 14th and 15th, promises to be the largest and most successful meeting in the entire history of the Association. The headquarters, scientific and commercial exhibits, meetings of committees, the Council, the House of Delegates and the general scientific sessions and annual banquet will be held under the same roof. An innovation will be the first annual meeting of the Woman's Auxiliary. This will add much to the enjoyment of the occasion.

The Committee on Scientific Work has wisely limited the papers to a number which can be finished during the three days of the scientific program. This will insure each essayist an opportunity to be heard and to have his paper discussed by those interested in his subject.

We are particularly fortunate in having as our guests Surgeon Edward Francis, of the U. S. P. H. S., who will deliver an address on "Tularaemia" at the banquet on



Thursday night and Dr. Walter E. Sistrunk, of the Mayo Clinic, who will read a paper on "Surgery of the Colon," on Friday morning.

Much important business is to come before the House of Delegates on Tuesday night, preceding the opening session on Wednesday morning. A full attendance of all qualified Delegates is essential for the best interests of the Association.

---

### **The Seventh Annual Session of The Railway Surgeons Association of Georgia**

To be held in the Convention Hall of the Biltmore Hotel, Atlanta, Ga., May the 12, 1925, on the day previous to the regular annual meeting of the Medical Association of Georgia.

The official program will be mailed out about one week before the meeting giving an account in detail.

The scientific part of the program will consist of a Symposium on "Infections as Viewed from the Railroad Standpoint." There will be five papers on this Symposium by able Railroad Surgeons of Georgia.

The Chief Surgeons of all the Railroads that touch or traverse Georgia will be present and address the members of the Association.

One of the most important matters to come before the meeting is the question of foreign transportation. To get results or favorable action on this question every Railroad Surgeon in Georgia should be present to help in this matter.

Dr. Hugh M. Lokey, of Atlanta, is chairman of Arrangement Committee and has all local matters in hand for the meeting.

#### **Officers of the Association**

President, Dr. Cleveland Thompson, Milen.

1st Vice-President, Dr. Jabez Jones, Savannah.

2nd Vice-President, Dr. H. M. Stowe, Jesup.

3rd Vice-President, Dr. W. K. Smith, Pembroke.

#### **Executive Committee**

Dr. A. G. Fort, Chairman, Atlanta.

Dr. Thomas H. Hancock, Atlanta.

Dr. A. R. Rozar, Macon.

Dr. J. M. Spence, Camilla.

Dr. H. C. Wheelchel, Douglas.

Dr. J. W. Palmer, Secretary and Treasurer, Ailey.

I know that the meeting of the Southern Railway Surgeons Association in Savannah conflicts with ours, but as we have only one day and the Southern three days, you can be with us on the 12th and register for the meeting of the Medical Association of Georgia and over night go to Savannah and have one to two days there. Do this and you will be attending three meetings practically at the same time.

Respectfully submitted,

J. W. PALMER, Secretary.

---

### **THE LIST OF APPROVED HOSPITALS HAS BEEN REVISED**

The 1925 revised list of hospitals approved for internships by the Council on Medical Education and Hospitals of the A. M. A. appears in the Hospital Number of The Journal for March 28. The list was first published by the Council in 1914, in response to a growing demand for such a list for the guidance on medical graduates and others seeking a year or more of hospital experience. It has since been revised every two years until 1922 and annually since that time.

The approved list at present contains only general hospitals that are in position to furnish full-rounded internships such as satisfy the medical colleges and state boards as well as meet the almost universal demand of medical graduates for at least a year's hospital experience before either general practice or specialization. The Council also issues a list of hospitals that provide residencies in the specialties for graduates who have already served a general internship.

## District and County Societies

The Secretary of each county society shall report to the Journal of the Medical Association of Georgia full minutes of each meeting and forward to it all scientific

papers and discussions which the society shall consider worthy of publication.—Constitution and By-Laws, Chap. VII, Sec. 15.

1. Demmond, E. Carson, Savannah.
2. Wood, A. W., Albany.
3. Greer, Chas. A., Oglethorpe.
4. Blackmar, Francis B., Columbus.
5. Clay, Grady E., Atlanta.
6. Hawkins, T. I., Griffin.

7. McCord, M. M., Rome.
8. Carter, D. M., Madison.
9. Bennett, J. C., Jefferson.
10. Lee, F. Lansing, Augusta.
11. Penland, J. E., Waycross.
12. Cheek, O. H., Dublin.

### HONOR ROLL

The following is a list of 100 per cent counties for 1925. The date on which each became a 100 per cent society appears after the name of the society, together with the name of the Secretary:

1. Randolph County, Dr. G. Y. Moore, Cuthbert, December 9, 1924.
2. Dougherty County, Dr. J. A. Redfearn, Albany, December 10, 1924.
3. Pike County, Dr. M. M. Head, Zebulon, December 12, 1924.
4. Hart County, Dr. W. E. McCurry, Hartwell, January 3, 1925.
5. Warren County, Dr. A. W. Davis, Warrenton, January 14, 1925.
6. Monroe County, Dr. W. J. Smith, Juliette, January 14, 1925.
7. Lamar County, Dr. John M. Anderson, Barnesville, March 6, 1925.
8. Upson County, Dr. B. C. Adams, Thomaston, March 30, 1925.

### SEVENTH DISTRICT MEDICAL SOCIETY

The Seventh District Medical Society met in Cedartown Wednesday, April 1st, for their Spring meeting. An unusually large attendance was present. Polk County Medical Society entertained the District Society royally. Nothing was left undone. A more hospitable bunch of doctors cannot be found anywhere than the fellows of Polk County. A unanimous vote of thanks was extended to the entertaining Society.

The Society met at the Cherokee Club Rooms and listened to the program up until 1 p. m., then they retired to Wayside Inn, where after a most sumptuous repast, the program was continued. Vice-President Dr. Trammell Starr acted as President in the absence of Dr. R. E. Wilson. Dr. M. M. McCord was present as Secretary.

The address of welcome in behalf of the City of Cedartown was delivered by Dr. John W. Good, Mayor. In behalf of the Polk County Medical Society, the address was delivered by T. E. McBride, of Rockmart. The response to the addresses of welcome was delivered by Dr. Howard E. Felton, of Cartersville.

The District Society was honored by the presence of Dr. J. O. Elrod, President Medical Association of Georgia, Dr. Allen H. Bunce, State Secretary, Dr. L. E. Brawner, recently of Massachusetts Eye and Ear Infirmary but now of Atlanta, and Dr. N. M. Owensby, of Atlanta.

In the election of officers the results were as follows:

President, Dr. Trammell Starr, Dalton.

Vice-President, Dr. Henry M. Hall, Cedartown.

Secretary and Treasurer, Dr. M. M. McCord, Rome.

The Society accepted the invitation of Gordon County Medical Society extended by Dr. Z. V. Johnston, of Calhoun, to be their guests at the September meeting.

The program was taken up as follows:

"What the Physician Owes His Profession, Dr. J. O. Elrod, Forsyth.

"Bandaging With Demonstration," Dr. John W. Good, Cedartown.

"The Responsibility of the General Practitioner in Surgical Conditions," Dr. J. T. McCall, Rome.

"The Use of Psychotherapy in the Every Day Practice of Medicine," Dr. Newdigate M. Owensby, Atlanta.

"Middle Ear Diseases with Complications and Sequelae," Dr. Leon E. Brawner, Atlanta.

## Symposium—Weaning the Baby.

"Methods of Weaning," Dr. M. M. McCord, Rome.

"Importance of Early Weaning," Dr. R. C. Maddox, Rome.

The Committee on Reception was as follows: Drs. C. W. Peek, W. G. England, H. M. Hall, J. J. Cooper and J. E. Pennington.

The Committee on Arrangement was: Drs. E. H. Richardson, C. Van Wood and P. O. Chaudron.

Dr. Howard E. Felton made a very interesting report on Necrology, and Dr. J. P. Bowdoin made a very instructive report on Public Health Activities.

Respectfully submitted,

M. M. McCORD, M. D., Secretary.

### PROGRAM OF MUSCOGEE COUNTY MEDICAL SOCIETY 1925

#### Officers

President, Dr. W. P. Jordan.

Vice-President, Dr. J. H. Pennington.

Secretary, Dr. Francis Blackmar.

#### March 5th

##### Business

"Treatment of Syphilis"-----Dr. W. P. Jordan  
Discussion Opened by-----Dr. Bert Tillery

#### April 2nd

#### PEDIATRIC SESSION

"Scarlet Fever"-----Dr. Mercer Blanchard  
Discussion Opened by-----Dr. R. P. Griffith  
"Bronchopneumonia"-----Dr. R. P. Griffith  
Discussion Opened by-----Dr. Frank Norman  
"Pyelitis"-----Dr. Frank Norman  
Discussion Opened by-----Dr. Mercer Blanchard

#### May 7th

##### Business

"Menstrual Disturbances"-----Dr. G. S. Murray  
Discussion Opened by-----Dr. J. H. McDuffie, Jr.

#### June 4th

#### SESSION ON ANAESTHESIA

##### Business

"General Anesthetic Agents"-----Dr. C. A. Dexter  
Discussion Opened by-----Dr. O. C. Brannen  
"Regional Anesthesia"-----Dr. Bert Tillery  
Discussion Opened by-----Dr. A. N. Dykes

#### June 18th

### FOURTH DISTRICT MEDICAL SOCIETY MEETING

#### July 2nd

#### OBSTETRICAL SESSION

"Eclampsia"-----Dr. J. C. Wooldridge  
Discussion Opened by-----Dr. J. H. McDuffie

"Pre-natal Care"-----Dr. J. H. McDuffie, Jr.  
Discussion Opened by-----Dr. J. H. Pennington  
"Indications, Contra-indications and Application  
of Forceps"-----Dr. J. H. Pennington  
Discussion Opened by-----Dr. J. C. Wooldridge

#### August 6th

"The Systematic Analysis of Cases"

-----Dr. W. F. Jenkins  
Discussion Opened by-----Dr. J. A. Thrash  
"Practical Hints for the Industrial Surgeon"  
-----Dr. A. N. Dykes  
Discussion Opened by-----Dr. J. M. Anderson

#### September 3rd

##### Business

"The Acute Abdomen"-----Dr. W. L. Cooke  
Discussion Opened by-----Dr. G. S. Murray

#### October 1st

#### OTOLARYNGOLOGICAL SESSION

"Interstitial Keratitis"-----Dr. J. M. Baird  
Discussion Opened by-----Dr. C. B. Carter  
"The Treatment of Diphtheria"  
-----Dr. Francis Blackmar  
Discussion Opened by-----Dr. J. A. Thrash  
"Swimming Pool Infections"-----Dr. C. A. Peacock  
Discussion Opened by-----Dr. G. F. Chambers

#### November 5th

##### Business

"Gastric and Duodenal Ulcers"  
Medical Treatment-----Dr. James De Lamar  
Discussion Opened by-----Dr. C. A. Dexter  
Surgical Treatment-----Dr. F. L. Cosby, Jr.  
Discussion Opened by-----Dr. W. L. Cooke

#### December 3rd

Election of Officers for 1926

### WHAT WARE COUNTY IS DOING

To the Secretary:

I am enclosing our program of last night which was carried out in full, with 21 present.

The Ware County Medical Society has subscribed for five Hygeias to be distributed to the schools of the city each month.

We are running a weekly column in the local paper on health and sanitation.

We have elected a County Health Officer under the Ellis Health Law.

J. E. PENLAND, M. D., Secretary.

April 2, 1925.

Waycross.

Drs. B. H. Minchew, R. L. Johnson and Chas. M. Stephens read papers at this meeting.



### FULTON COUNTY MEDICAL SOCIETY

A very interesting meeting of the Fulton County Medical Society was held Thursday, April 2nd, at the Academy of Medicine, 32 Howard Street, Atlanta.

Dr. W. W. Blackman gave an "Exhibition of Apparatus for Improved Colon Irrigation." Dr. B. T. Beasley reported a case of "Ileo Appendiceal Fistula with Acute Appendicitis and General Peritonitis." This case report was discussed by Dr. T. C. Davison.

"Liver Abscess Amoebic," by Dr. Floyd McRae, was discussed by Drs. H. C. Sauls, F. K. Boland and H. R. Donaldson. Dr. W. F. Westmoreland read a paper on "Surgery of the Inguinal Hernia." This paper was discussed by Drs. W. E. Person, T. C. Davison, Barfield, H. R. Donaldson, F. K. Boland, E. C. Thrash.

"Compensatory Changes in Diseases of the Lungs" was the title of a paper read by Dr. C. C. Aven. This paper was discussed by Drs. C. H. Holmes, E. C. Thrash, A. B. Elkin.

Resolutions upon the death of Dr. L. P. Stephens were read and a copy sent to the lay press and the original filed with the minutes of the meeting of the Society.

Respectfully submitted,  
GRADY E. CLAY, Secretary.

### THE THOMAS COUNTY MEDICAL SOCIETY

A regular meeting of the Thomas County Medical Society was held at Ochlocknee, April 15, 1925. The business session was called to order by the Vice-President, Dr. Henry Jones, Coolidge, in the absence of the President, Dr. S. L. Cheshire, Thomasville. The minutes of the last meeting were read and adopted as read.

Dr. J. W. Read, Thomasville, presented a paper on "The Influence of Heredity on Diseases as Found in General Practice." This was a splendid paper and was ably discussed by Drs. W. W. Jarrell, Henry Jones and C. K. Wall.

At this point Dr. Cheshire arrived and presided over the remainder of the meeting.

Dr. M. E. Winchester, County Health Commissioner, read a very helpful paper on "Reciprocity between the Public Health Men and the Medical Profession," which was discussed by Dr. W. W. Jarrell.

It was moved and carried that a call meeting be held in Thomasville on the 2nd Wednesday in May and at that time determine whether or not to make Thomasville the permanent meeting place of the Society.

The business session then adjourned and those attending repaired to the home of Dr. W. H. Worrill, where a most delightful five course dinner was served. This was a special treat and not only did the visiting physicians enjoy the delicious and bountiful dinner but the fellowship and association of this hospitable home as well. The Society thoroughly enjoyed the dinner and entertainment offered by Dr. and Mrs. Worrill.

Respectfully submitted,  
C. K. WALL, M. D., Secretary.

### SPALDING COUNTY MEDICAL SOCIETY

The meeting of the Spalding County Medical Society was held Tuesday night, April 7, 1925, in the offices of Dr. W. H. Austin, Griffin. It was presided over by Dr. K. S. Hunt, Griffin, President.

Drs. Huckaby and Beason, who have recently moved into the County, were elected to membership.

It was announced at the meeting that Dr. M. F. Carson, Griffin, would shortly move to Miami, Florida, to reside. Resolutions were adopted by the Society expressing its regret at the departure of Dr. Carson, who has been practicing in Griffin for 25 years.

A buffet supper was served following the business session.

### COUNTY SOCIETIES REPORTING FOR 1925

#### SCREVEN COUNTY MEDICAL SOCIETY

The Screven County Medical Society announces the following officers for 1925:

President, Dr. W. R. Lovett, Sylvania.  
Secretary, Dr. A. B. Reddick, Sylvania.

Treasurer, Dr. L. F. Lanier, Rocky Ford.

### **MADISON COUNTY MEDICAL SOCIETY**

The Madison County Medical Society announces the following officers for 1925:

President, Dr. H. H. Hampton, Colbert.

Secretary-Treasurer, Dr. W. D. Gholston, Danielsville.

Delegate, Dr. R. J. Westbrook, Ila.

Alternate, Dr. C. L. Loden, Colbert.

Board of Censors, Drs. G. P. Loden, Colbert; L. E. Roper, Comer, and R. J. Westbrook, Ila.

### **FRANKLIN COUNTY MEDICAL SOCIETY**

The Franklin County Medical Society announces the following officers for 1925:

President, Dr. Stewart D. Brown, Royston.

Vice-President, Dr. W. B. Heller, Lavonia.

Secretary-Treasurer, Dr. B. T. Smith, Carnesville.

Delegate, Dr. J. O. McCrary, Royston.

Alternate, J. M. Freeman, Lavonia.

Board of Censors, Drs. W. W. Carnog, Lavonia; E. T. Poole, Carnesville, and H. L. McCrary, Royston.

### **ELBERT COUNTY MEDICAL SOCIETY**

The Elbert County Medical Society announces the following officers for 1925:

President, Dr. D. V. Bailey, Elberton.

Vice-President, Dr. A. S. Johnson, Elberton.

Secretary-Treasurer, Dr. J. C. Hudgens, Elberton.

Delegate, Dr. A. C. Smith, Elberton.

### **LAURENS COUNTY MEDICAL SOCIETY**

The Laurens County Medical Society announces the following officers for 1925:

President, Dr. J. E. New, Dexter.

Vice-President, Dr. C. A. Hodges, Dublin.

Secretary-Treasurer, Dr. O. H. Cheek, Dublin.

Delegate, Dr. O. H. Cheek, Dublin.

Alternate, Dr. E. B. Claxton, Dublin.

Board of Censors, Drs. E. B. Claxton, Dublin, and W. C. Shellnut, Dublin.

### **FLOYD COUNTY MEDICAL SOCIETY**

The Floyd County Medical Society announces the following officers for 1925:

President, Dr. R. O. Simmons, Rome.

Vice-President, Dr. A. F. Routledge.

Secretary-Treasurer, Dr. J. H. Mull, Rome.

Delegate, Dr. Cliff Moore, Lindale.

Alternate, Dr. J. L. Garrard, Rome.

Board of Censors, Dr. W. J. Shaw, Rome.

### **GORDON COUNTY MEDICAL SOCIETY**

The Gordon County Medical Society announces the following officers for 1925:

President, Dr. M. A. Acree, Calhoun.

Vice-President, Dr. W. R. Barnett, Calhoun.

Secretary-Treasurer, Dr. R. B. Chastain, Calhoun.

Delegate, Dr. Z. V. Johnston, Calhoun.

Board of Censors, Drs. C. F. McLain, Calhoun; W. R. Richards, Calhoun, and S. F. Hutcherson, Adairsville.

### **JASPER COUNTY MEDICAL SOCIETY**

The Jasper County Medical Society announces the following officers for 1925:

President, Dr. L. Y. Pittard, Monticello.

Vice-President, Dr. J. A. Brown, Shady Dale.

Secretary-Treasurer, Dr. E. M. Lancaster, Shady Dale.

Delegate, Dr. R. F. Carey, Monticello.

Alternate, Dr. F. S. Belcher, Monticello.

### **BULLOCH-CANDLER COUNTIES MEDICAL SOCIETY**

The Bulloch-Candler Counties Medical Society announces the following officers for 1925:

President, Dr. A. Temples, Statesboro.

Vice-President, Dr. Clifford Miller, Port.

Secretary-Treasurer, Dr. F. F. Floyd, Statesboro.

Board of Censors, Drs. A. J. Bowen, Port; B. B. Jones, Metter, and J. H. Whiteside, Statesboro.

### CHATTOOGA COUNTY MEDICAL SOCIETY

The Chattooga County Medical Society announces the following officers for 1925:

President, Dr. R. E. Tally, Trion.

Vice-President, Dr. E. M. Jennings, Menlo.

Secretary-Treasurer pro tem, Dr. W. B. Hair, Summerville.

Board of Censors, Drs. L. A. Mallicoat, Trion; M. N. Wood, Menlo, and G. E. Martin, Menlo.

### THE WOMAN'S AUXILIARY TO THE GEORGIA MEDICAL SOCIETY

A meeting was called at the Georgia Medical Society Building, Savannah, on April 3, 1925, to organize an Auxiliary to the Georgia Medical Society (Chatham County), with Mrs. W. H. Myers, District Chairman, presiding.

Mrs. J. W. Daniel acted as Secretary. Twenty-four ladies were present. A letter was read from the State President outlining the plans and purposes of the organization which will be composed of wives and widows of physicians, who are, or were, members of the Medical Association of Georgia. The Secretary read the proposed Constitution and By-Laws, which were adopted.

The Nominating Committee, composed of Mrs. George White, Mrs. R. V. Martin and Mrs. A. J. Waring, Chairman, presented the following for officers: President, Mrs. J. N. Carter; 1st Vice-President, Mrs. John K. Train; 2nd Vice-President, Mrs. H. H. Martin; Recording Secretary, Mrs. Ralston Latimore; Corresponding Secretary, Mrs. William R. Dancy. The report was accepted and the Secretary was instructed to cast the ballot. Mrs. A. J. Waring and Mrs. W. R. Dancy were elected Delegates to the State meeting that meets in Atlanta May 13, 14, 15, 1925.

Respectfully submitted,

KATHERINE DANIEL, Acting Secretary.

### THE WOMAN'S AUXILIARY TO THE JACKSON COUNTY MEDICAL SOCIETY

Mrs. J. H. Downey, of Gainesville, and Mrs. S. J. Smith, of Jefferson, recently called together the wives of the doctors who were members of the Jackson County Medical Society and the Medical Association of Georgia. The meeting was held at the home of Mrs. J. H. Campbell, Jefferson. At this meeting the Woman's Auxiliary to the Jackson County Medical Society was organized.

The members were enthusiastic and very much interested. It is believed that every doctor's wife in Jackson County will be a member and attend the meeting of the State Association to be held in Atlanta, May 13th-15th.

Among those present were Mrs. L. C. Allen, Mrs. M. B. Allen, and Mrs. Ralph Freeman, Hosehton; Mrs. J. C. Bennett, Mrs. J. H. Campbell, Mrs. E. M. McDonald and Mrs. S. J. Smith, all of Jefferson.

### Woman's Auxiliary to Clarke County Society

A meeting was held Friday, the 15th of March, at the home of Mrs. Paul Holliday to discuss plans for forming an auxiliary to the Clarke County Medical Association. The following doctors wives were present: Mrs. C. J. Decker, Mrs. J. C. McKinney, Mrs. S. S. Smith, Mrs. W. H. Cabiness, Mrs. G. O. Wheelchel, Mrs. J. S. Stewart, Mrs. A. A. Rayle, Mrs. A. C. Holliday, Mrs. J. D. Applewhite, Mrs. H. M. Fullilove, Mrs. G. T. Canning, Mrs. J. C. Holliday, Mrs. P. L. Holliday.

The officers elected were: Mrs. Paul Holliday, President; Mrs. J. S. Stewart, Vice-President, and Mrs. H. M. Fullilove, Secretary and Treasurer. Members were assessed \$1.00 per year, amount to be used for stationery, State dues, and entertainments.

A committee to formulate a constitution and by-laws for the auxiliary was appointed composed of Mrs. Applewhite, Mrs. Smith and Mrs. Cabiness. April the 17th was the date agreed upon for the next meeting, to be held at the home of Mrs. J. S. Stewart, after which the meeting adjourned.

MRS. H. M. FULLILOVE, Secretary.



## OPPORTUNITIES FOR GRADUATE MEDICAL STUDY IN NEW YORK

The Committee on Medical Education of the New York Academy of Medicine has prepared a series of synopses of approved opportunities for graduate medical study in New York City which will soon be published for distribution. The synopses cover dermatology and syphilology, obstetrics and gynecology, internal medicine, neurology and psychiatry, ophthalmology, otolaryngology, pediatrics, surgery, urology, and orthopedic surgery.

A Bureau of Clinical Information is maintained at the Academy of Medicine, 17 West 43rd Street, where detailed information is available regarding opportunities for graduate medical study in New York, and also in other cities of the United States and abroad. The Executive Secretary in charge of the Bureau is prepared to answer inquiries concerning ordinary internships, special internships or residencies, graduate courses in medical schools and teaching hospitals, and extension courses. Much information in regard to graduate medical work in England and on the Continent is on file.

The Bureau publishes a Daily Bulletin of Surgical Clinics which will be mailed free to visiting doctors on request. A Weekly Bulletin of Medical Clinics also is published. A book of the fixed clinics of Greater New York, with a transportation guide, has been prepared for the use of visitors whose stay in the city is limited, and is furnished without charge.

### A HIGH STANDARD

Every batch of Nearsphenamine, produced in The Dermatological Research Laboratories is required to pass a toleration test of 400 mgs. or better per kilo, of bodyweight as against the government requirement of 240 mgs. This is in excess of 60 per cent higher than the official standard.

This high toleration combined with a curative value practically equal to Arsphenamine places the D. R. L. product in a class by itself.

Literature on request to The Abbott Laboratories, Chicago.

## AMPOULE SOLUTIONS DAILY GROWING IN POPULARITY

The ampoules that are particularly to be recommended are made of imported glass, glass containing no soluble alkali that might have an effect upon the medicament. The ampoules, after being filled, are closed hermetically, under a gas flame; in other words, the glass at the neck is melted and fused, and the container is thus made airtight and watertight. In addition to this protection, it is necessary in some cases to protect the solution from the effect of light, and the ampoules are therefore put up in cardboard cartons which exclude the light.

All of which goes to show that conveniences are not gratuitous, but must be paid for by either the manufacturer or the user. In this case the manufacturer pays the major part of the price in the care required for assaying, sterilizing and encasing the medicinal solutions; but the user is supposed to keep the ampoules in their respective packages, and not let them lie around loose, until they are needed. In some cases, too, it is quite important that the date stamped on the package be consulted, for the ampouled solutions are not all indefinitely stable. This reasonable care cannot be considered a high price to pay for the convenience of having at hand a sterilized solution in individual doses for subcutaneous, intramuscular or intravenous administration.

Some of the merits of this class of products are tersely set forth in the advertisement on "Ampoules," by Parke, Davis & Co., which appears in this issue of The Journal.

### AMERICAN BOARD OF OTOLARYNGOLOGY

The next examination conducted by the American Board of Otolaryngology will be held at the Ambassador Hotel, Atlantic City, on Tuesday, May 26th at 9 a. m.

Application blanks may be obtained from Dr. H. W. Loeb, Secretary, 1402 South Grand Boulevard, St. Louis, Mo.

## Medical Progress

With the cooperation of our associates we propose to publish under "Medical Progress" abstracts from current medical literature of general interest to the

profession. Members of the association are invited to contribute to this Department.

Anderson, W. W., Pediatrics  
Ballenger, E. G., Urology  
Bartholomew, R. A., Obstetrics  
Block, E. B., Neurology and Psychiatry  
Clay, Grady E., Ophthalmology  
Downman, C. E., Neuro-Surgery  
Eguen, M. S., Otology, Laryngology and Rhinology  
Fitts, Jno. B., Internal Medicine  
Greene, E. H., Surgery

Hodgson, F. G., Orthopedics  
Holmes, Walter R., Gynecology and Female Urology  
Jones, Jack W., Dermatology  
Klugh, Geo. F., Clinical Pathology  
Landham, J. W., X-Ray and Radium  
Pruitt, M. C., Proctology  
Thrash, E. C., Internal Medicine  
Waits, C. E., Surgery

### DIAGNOSTIC ERRORS LEADING TO UNCALLED FOR APPENDECTOMY

Henry Wald Bettmann, Cincinnati (Journal A. M. A., Oct. 18, 1924), collected from private practice reports of some 300 cases in which appendectomies had been performed without relief. Patients could not always furnish accurate histories. Every case in which the history was uncertain or inconclusive was rejected. This rigorous censorship left only 170 cases for statistical presentation, although fifty other cases had features of practical importance. A careful analysis of the 170 cases led to the rather startling conclusion that fully two-thirds of all the patients had never been carefully studied before the operation, and the indications for any operation in at least one-third of the cases were very imperfect indeed. Not one-third of the patients had had a competent and thorough examination in the modern sense. Not that large a proportion had had an analysis of the gastric juice, any adequate observation under proper dietetic conditions or a complete roentgen-ray examination. Many were subjected to operation "on suspicion" because their digestive disturbances had resisted medical treatment and because many of them presented right iliac sensitiveness, gaseous distention or other signs or symptoms that seemed to point to the possibility of chronic appendicitis. In more than one-third of the cases the indications for an operation were quite insufficient. Of the 300 patients, thirty-five complained of serious disorders traceable to the operation itself. The commonest sequels were hernia, ileac stasis, omental and other adhesions, and neurasthenia.

### POSSIBLE CAUSES OF RENAL BLEED- ING WHICH CANNOT BE ACCU- RATELY DIAGNOSED

The existence of hematuria without a definite cause has always been doubted by George R. Livermore, Memphis, Tenn. (Journal A. M. A., Nov. 1, 1924), and a review of the literature confirmed his opinion. Stricture of the ureter is a frequent cause of so-called essential hematuria, as two cited cases demonstrate. He also reports a case of hematuria caused by movable kidneys; a case of infection and cystic degeneration of the kidney responsible for profuse hematuria; and a case of tuberculosis of the kidney responsible for hematuria, which cleared up for fourteen months following pelvic lavage. These and other cases forcibly emphasize the fallacy of temporizing in cases of renal hematuria.

### SIGNIFICANCE OF THE BASAL METABOLISM DETERMINATION

A summary of the results of 500 basal metabolism determinations on 437 office patients is given by Alvan L. Barach and George Draper, New York (Journal A. M. A., March 7, 1925). The determination of the basal metabolism was usually performed for the purpose of acquiring diagnostic or prognostic aid. The determination of the basal metabolism in office practice requires no change in the standards used for patients in the hospital, provided basal conditions are rigidly observed. It seems better to adopt 15 per cent, as the range for normals and miscellaneous controls, rather than 10 per cent. The value of the metabolism test in clinical practice seemed to be largely in the exclusion of the thyroid gland as cause of the patient's symptoms. In a small percentage of cases (7.3 per cent of the total number), the metabolism determination established a diagnosis of hyperthyroidism or hypothyroidism which, from the clinical examination alone, was in doubt or overlooked. It was of especial value in the detection of hypothyroidism. Hypothyroidism in the absence of clinical myxedema warrants further consideration. Its recognition would seem to be of some importance, since beneficial efforts follow the administration of thyroid extract in many of these cases.

## NEWS ITEMS

Dr. Arch Elkin, 436 Peachtree Street, Atlanta, announces that Dr. J. F. Arthur is now associated with him. Practice limited to Internal Medicine and Endocrinology.

Mrs. R. L. Carter was hostess to the Upson County Medical Society of which her husband is an honored member, March 18, 1925, at her home in Thomaston. Covers were placed for Drs. A. H. Black, H. A. Barron, Bentley Adams, E. W. Carter, K. S. Williams, J. M. McKenzie, R. L. Carter, all of Thomaston, and C. A. Harris, of The Rock.

The friends of Dr. DeLamar Turner, Chatham County Health Officer, will be interested to learn of his return to Savannah after having been under treatment in the Rawlings Sanitarium, at Sandersville, and that he is on the road to recovery.

Dr. George A. Paulk, of Tifton, sent in his resignation to Governor Walker as a member of the Georgia Industrial Commission, as he has decided to move to Miami, Florida, to continue the practice of medicine. He is a past member of the House of Representatives from Berrien County, the State Senate and the Berrien-Lanier Medical Society.

Dr. James Andrew, formerly of Macon, has moved to Littleton, Alabama, and is connected with the Banner Mines. He is a member of the Bibb County Medical Society.

Drs. H. B. Allen and L. F. Grubbs have consolidated their offices in Americus and are practicing under the name of the Eye, Ear and Nose Clinic. Their offices are in the New Doctors' Building, which was formerly the Y. M. C. A. Building. Other doctors occupying this building are Drs. W. S. Prather, J. W. Chambliss, J. T. Stukes, general practitioners and surgeons, A. C. Primrose, who has installed a radium and x-ray clinic, and J. W. Payne, Sumter County Health Physician.

Dr. L. A. Baker, of Tifton, has been appointed by Governor Walker as a member of the Georgia State Board of Medical Examiners. Dr. Baker is a member of the Tift County Medical Society and represented his Society as Delegate at the annual meeting last year.

Dr. Leon Edward Brawner, a recent House Surgeon of the Massachusetts Eye and Ear Infirmary, announces the opening of his offices at 79 Forrest Avenue, Atlanta. Practice limited to the Diseases of the Ear, Eye, Nose and Throat. Dr. Brawner is removing to Atlanta from Cairo.

Dr. J. H. Terrell, Jr., formerly practicing in Canon, is now located in Lavonia. Dr. Terrell will still continue his membership in the Franklin Medical Society as Lavonia is in Franklin County.

Dr. O. E. Hampton is now connected with Dr. Jere L. Crook in Jackson, Tennessee. He was formerly of Colbert. Dr. Hampton is a member of the Madison County Medical Society and a son of Dr. H. H. Hampton, Colbert, who is president of the Society.

The Screven County Medical Society entertained the First District Medical Society at their meeting held in Sylvania, April 8, 1925.

A meeting of the Savannah graduates and former students of the Johns Hopkins University was held at the home of the Georgia Medical Society March 31, 1925. Members of the Chatham County Medical Society present were: Drs. William R. Dancy, Walter S. Wilson, Gordon L. Groover, Jr., Lee Howard, E. C. Demmond and Victor H. Bassett.

The Augusta Chapter of the Johns Hopkins Alumni Association was formed April 2, 1925. Dr. W. C. Kellogg was elected President and Dr. C. S. Lentz, Secretary-Treasurer. Among the doctors present were: W. C. Kellogg, Joseph Akerman, H. B. Nealge, R. L. Rhodes, V. P. Sydenstricker and C. S. Lentz; former faculty members: L. P. Holmes; former students: W. A. Mulherin and T. E. Oertel.

Dr. Fred A. Sprague has moved his offices from 553 Walnut Street, Macon, to Leesburg, Florida. He was a former member of the Bibb County Medical Society.

Mrs. Henry S. Wright presented a painting, "Southern Hospitality," to the Fulton County Medical Society at its meeting April 2, 1925, in memory of her husband, who was one of the most prominent members of the medical profession up until his death in 1911. Dr. C. W. Strickler, Atlanta, received the painting in behalf of the Society.

The Savannah Hospital opened an out patient clinic for patients suffering with diabetes and heart and kidney diseases. Only those who are unable to pay for medical treatment will be allowed this benefit.

The American Proctologic Society will hold its annual meeting at the Ambassador Hotel, Atlantic City, N. J., May 25-26, 1925.



**COMMUNICATIONS.**

A Good Word for our Printers

Dear Dr. Bunce:

Enclosed find corrected copy of paper as per your request.

I want to congratulate whoever set up this type in getting it as near letter for letter as they did.

I wrote you when I sent you this paper originally, to have me two or three hundred reprints made. I have had a number of requests from my friends for reprints, so I am going to change this and ask you, if you will, to have me about 1,500 reprints made.

Let me know what this expense will be and a check for same will be forthcoming.

Thanking you in advance, I am,

Yours fraternally,

T. E. ROGERS.

Macon, Ga.

April 9, 1925.

Dr. Stewart R. Roberts,  
Atlanta, Ga.

Dear Doctor Roberts:

There is a plan on foot to have a dinner on Wednesday of A. M. A. week at Atlantic City, of all the former Medical Officers of the World War. I have been asked to tell them in this part of the country and I would like your co-operation as regard to Georgia and the Southern Medical. If you could have a notice in your State Journal and the Journal of the Southern Medical Association, over your signature, I think that would be all that is necessary. More definite information will appear in the Journal of the A. M. A. and can be obtained at the meeting. I hope you will co-operate and that you will be able to attend the dinner.

With kindest regards, I remain

Yours very truly,

E. C. ELLETT, M. D.

Memphis, Tenn.

Dr. Roberts extends a cordial invitation

to all the members of the Association who were former Medical Officers during the World War to attend this dinner.

To The Editor:

Resolution offered by Dr. A. L. Crittenden, Shelhman, Ga., and adopted by the Randolph County Medical Society:

Be it resolved by the Randolph County Medical Society that we believe that a State law, requiring all dogs in the State to be given single dose preventive treatment against rabies. That this material should be furnished free if possible, but if not, should be provided at a small cost by the State Board of Health.

That all dog owners be required to register the date when this dog was treated with police officer of the town or county, and that the dog be required to wear a collar with dated tag showing that he has been treated, and all dogs not bearing such tags or so registered be shot on sight.

Be it further resolved that the State Board of Health, our Senator and Representative be mailed a copy of this resolution, and request them to ask the State Legislature to enact such a law.

The Randolph County Medical Society,  
G. Y. MOORE, Sec.

Cuthbert, Ga.

To the Editor:

I know of a case that seems to me would be interesting reading for your Journal, being a little unusual.

Dr. J. T. Henley, formerly of Atlanta, now living in Douglasville, Ga., and old customer and friend of ours, went out in a pasture some sixty days ago, came in contact with a bull, and said bull gored him severely, tearing open a good part of the abdomen and exposing the popliteal artery.

Upon being carried to the house, he deliberately lay down, took needle and silk and sewed this place up himself. It seems

to me that this is an unusual incident. You can write the doctor for more details if you think it worth while.

Yours very truly,

LOUIS ESTES,

Estes Surgical Supply Co.

Atlanta, Ga.

Dear Doctor:

The following gem of therapeutics from as far back as 1556, I discovered quite by accident in reading the life of Sir Thomas Moore:

My wife was sick of the sweating sickness, who lying in so great extremity of that disease as by no invention or devices, that physicians in such ease commonly use (of whom she had divers, both expert, wise and well learned, then continually attendant upon her) she could be kept from sleep; so that both physicians, and all others despaired her health and recovery, and gave her over.

Her father (as he that most entirely tended her) being in no small grief for her, it came into his mind, that a glister should be the only way to help her, which when he had told the physicians, they by-and-by confessed that if there were any hope of health, that it was the very best help indeed, much marvelling of themselves, that they had not afore remembered it.

Then it was immediately ministered unto her sleeping, which she could by no means have been brought unto waking, and albeit after she was thereby thoroughly awaked, God's marks, evident undoubted token of death, plainly appeared upon her, yet she (contrary to all their expectations) was miraculously recovered, and at length again to perfect health restored.

I do not believe that you believe in old remedies, but if you do, and if my illness could be classed as "the sweating sick-

ness," and this man means "blister" when he says "glister," I am entirely satisfied with your present method of treatment.

Very sincerely,

April 17, 1925.

Dear Doctor:

The enclosed reprint is mailed you at this particular time to request your attention to our program and especially the fact that the coming legislature will be the last one to assemble in two years.

If we are to secure any additional legislation, you are, indeed, an important factor. Your influence with your legislator and senator is greater than any one else that is interested in our work and the legislation that will be fostered and urged by the Medical Association of Georgia.

We are anxious to see the appropriation for the State Board of Health put on a per capita basis and at least six cents should be given annually for the next two years so that we can give our state funds to our counties that will co-operate with us in health work. This should be increased two cents per capita each year until twelve or fourteen cents is at our disposal.

Will you not see your members of the assembly, and keep on seeing them?

Sincerely yours,

T. F. ABERCROMBIE, M. D.,

Commissioner of Health.

#### UNITED STATES CIVIL SERVICE EXAMINATION

The United States Civil Service Commission announces the following open competitive examination:

PHYSIOTHERAPY AIDE  
PHYSIOTHERAPY PUPIL AIDE  
PHYSIOTHERAPY ASSISTANT

Receipt of applications for the positions listed above will close April 11, May 9, and June 13. The date for the assembling of competitors will be stated on the admission cards sent to applicants after the close of receipt of applications. The examinations are to fill vacancies in the Veterans' Bureau and the Public Health Service.

The entrance salary for physiotherapy aide in the Public Health Service is \$1,020 a year, with quarters, subsistence, and laundry; and for physiotherapy pupil aide, \$720 a year, with quarters, subsistence and laundry; and for physiotherapy assistant, \$1,500 a year.

The entrance salary for physiotherapy aide in the Veterans' Bureau is \$1,680 a year. In this service the entrance salary ranges from \$1,000 to \$1,400 a year for physiotherapy pupil aide, and from \$1,320 to \$1,600 a year for physiotherapy assistant.

The duties of physiotherapy aides consist of administering physiotherapy in its several branches

—massage, electrotherapy, hydrotherapy, mechanotherapy, thermotherapy; active, passive, resistive, and assistive exercises and remedial gymnastics; keeping daily record of the work and progress of each and every patient coming under direction and treatment; making the required reports of the activities of the reconstruction work in physiotherapy.

The duties of physiotherapy pupil aides are the same as those for physiotherapy aides, except that they are pupils under the supervision and instruction of the chief aide in all the work above mentioned.

The duties of physiotherapy assistants are to administer to special cases the treatments of physiotherapy as massage, electrotherapy, hydrotherapy, thermotherapy, mechanotherapy; active, passive, and resistive exercises and remedial gymnastics; keeping a daily report of the work in progress on each patient coming under direction and treatment; making the required reports of the activities of the reconstruction work in physiotherapy.

Full information and application blanks may be obtained from the United States Civil Service Commission, Washington, D. C., or the secretary of the board of U. S. civil-service examiners at the post office or customhouse in any city.

#### UNITED STATES CIVIL SERVICE EXAMINATION

The United States Civil Service Commission announces the following open competitive examination:

JUNIOR MEDICAL OFFICER  
ASSISTANT MEDICAL OFFICER  
ASSOCIATE MEDICAL OFFICER  
MEDICAL OFFICER  
SENIOR MEDICAL OFFICER

Applications for the positions listed above will be rated as received until June 30. The examinations are to fill vacancies in various branches of the Government service, at entrance salaries ranging from \$1,860 to \$5,200 a year.

Applicants for these positions must have been graduated from a medical school of recognized standing, and, in addition, have had certain specified experience or postgraduate study. It is provided, however, that applicants for the position of junior medical officer who are senior students in a medical college, may be admitted to the examination subject to their submitting proof of actual graduation within six months from the date of making oath to the application.

The need is for eligibles who are qualified in the various specialties of medicine and surgery; there is no great need at this time for those who are qualified in general medicine or surgery.

Competitors will not be required to report for

examination at any place, but will be rated on their education, training, and experience.

Full information and application blanks may be obtained from the United States Civil Service Commission, Washington, D. C., or the secretary of the board of U. S. civil-service examiners at the post office or customhouse in any city.

#### To The Editor:

We are making a change in our system of reporting and collecting morbidity records.

The old system was to furnish you cards for each individual case. Under the new system we will mail you one card each week to be filled out and returned to us regardless of whether you have any cases of communicable diseases to report or not.

The cards will be mailed to you in an envelope with your name and address already on it and will not require any signature. This system has been simplified so as to be as little trouble to the physician as possible. All you have to do is fill in the data on the card, date it, and put it in the mail.

If you live in a county or city where there is a health officer, these cards will be furnished you by the health officer with his return address on them.

We are especially anxious to have more complete records of the reportable diseases throughout the state. It is only in this way that the state, city and county health departments can give adequate service to the people in helping to reduce specific infectious diseases.

The physicians of Georgia have always responded nobly to any call for the betterment of health conditions in our state, and we predict a hearty response to this change in reporting communicable diseases.

Sincerely yours,

T. F. ABERCROMBIE, M. D.,  
Collaborating Epidemiologist.

State Board of Health, Atlanta, Ga.

#### REAL BOARD OF HEALTH

Strolling along the quays of New York harbor, an Irishman came across the wooden barricade which is placed around the inclosure where emigrants suspected of suffering from contagious diseases are isolated.

"Phwat's this boarding for?" he inquired of a by-stander.

"Oh," was the reply, "that's to keep out fever and things like that you know."

"Indade!" said Pat, "Oi've often heard of the Board of Health, but it's the first time Oi've seen it!"—Canadian Druggist.



To The Editor:

A "marked copy" of the current issue of the Journal of the Medical Association of Georgia reached me yesterday and I have read the notice concerning the opening of my offices on page 36. I wish to thank you for the courtesy shown me, which is greatly appreciated.

I hope to have the pleasure of meeting you soon; we shall "shake hands" and get acquainted.

Sincerely,

LOUIS HOLTZ.

Atlanta, Ga.

### THE DEPARTMENT OF HEALTH, CITY OF NEW YORK, INAUGURATES A SPECIAL NEUROLOGICAL STUDY

The Commissioner of Health, City of New York, called together a small group of neurologists, pediatricists and public health experts, on January 7th, 1925, and requested them to constitute themselves a Research Committee to study epidemiological, diagnostic, clinical and therapeutic data, with relation to such diseases of the nervous system as acute anterior poliomyelitis, encephalitis lethargica and meningococcus meningitis. This investigation is to comprise a study of the data that have been accumulated in this and other cities and countries, with a view to furnishing a body of facts that will be of service in indicating the possible advances that can be made from a clinical and public health view, in the control, diagnosis and treatment of these diseases.

### BOOK REVIEW

**An Introduction to the Study of Mental Disorders**, by Francis M. Barnes, Jr., M. A., M. D., 295 pp. Publishers: C. V. Mosby Company, St. Louis, 1923.

This work shows the same thoroughness of purpose and high standard of scientific excellence that have characterized this author in his previously printed articles. It gives the general practitioner, in readable English, the information he would like to have regarding mental disorders. As a rule, works of this nature are too technical for general use among the profession but Dr. Barnes has happily eliminated this objectionable feature to a large extent. The work is primarily a series of lectures given to his class at the St. Louis University Medical School and the material has been condensed without omitting essentials. All phy-

sicians, and particularly those whose opportunities for observing mental disorders have been limited, will find this work an authoritative and satisfactory introduction to the subject.

NEWDIGATE M. OWENSBY, M. D.

### BOOKS RECEIVED

**Clinical Medicine for Nurses**—By Paul H. Ringer, A. B., M. D., Chief of Medical Service of the Asheville Mission Hospital, Asheville, N. C.; on Staff of Biltmore Hospital, Biltmore, N. C. Illustrated. Second Revised Edition. Price \$2.50 net. Publishers: F. A. Davis Company, Philadelphia.

**Pseudo Appendicitis**—By Thierry de Martel, Chirurgien des Hopitaux de Paris and Edouard Antoine, Medicin des Hopitaux de Paris. Authorized translation from the French by James A. Evans, A. B., M. D., Formerly Assistant Radiologist, Hospital St. Antoine, Paris. Illustrated with 41 engravings. Price \$3.00 net. Publishers: F. A. Davis Company, Philadelphia.

**From Infancy to Childhood**—(The Child from 2 to 6 years), by Richard M. Smith, M. D., Assistant Professor of Child Hygiene, Harvard University; Associate Physician, Children's Hospital; Visiting Physician, Infant's Hospital, Boston. Price \$1.25. Publishers: The Atlantic Monthly Press, Boston.

**Pediatrics, Vol IV of the Practical Medicine Series**, comprising 8 volumes on the year's progress in medicine and surgery. Under the general editorial change of Chas. L. Mix, A. M., M. D. Edited by Isaac A. Abt, M. D., Professor of Pediatrics, Northwestern University Medical School; Attending physician Michael Reese Hospital; with the collaboration of Johanna Heumann, M. D. Series of 1924. Price \$2.00. Publishers: The Year Book Publishers, Chicago.

**International Clinic**—(A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics,

Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otolology, Rhinology, Laryngology, Hygiene, and other Topics of Interest to Students and Practitioners, by the Leading Members of the Medical Profession Throughout the World). Edited by Henry W. Cattell, A. M., M. D., Philadelphia. Publishers: J. B. Lippincott Company, Philadelphia and London.

**Gynecology and Obstetrics, Vol V of the Practical Medicine Series**—Gynecology edited by Thos. J. Watkins, M. D., F. A. C. S., Professor of Gynecology, Northwestern University Medical School; Attending Gynecologist, St. Luke's Hospital, Chicago. Obstetrics edited by Joseph B. De Lee, A. M., M. D., Professor of Obstetrics, Northwestern University Medical School; Attending Obstetrician Chicago Lying-in and Mercy Hospitals; Consulting Obstetrician, Provident and Evanston Hospitals; with the collaboration of J. P. Greenhill, B. S., M. D., Adjunct Attending Obstetrician, Chicago

Lying-in Hospital and Dispensary; Instructor in Obstetrics, Northwestern University Medical School. Series of 1924. Price \$2.00. Publishers: The Year Book Publishers, Chicago.

#### OBITUARY

Dr. Charles F. Benson died at the age of 63, April 12, at his home, 521 Ponce de Leon Avenue, Atlanta. He was one of the outstanding members of the medical profession and had practiced in Atlanta for the past 43 years. His death came as a result of a fall sustained last summer while in Jacksonville, Florida, on a business trip. He had been confined to his bed since July as a result of the accident.

Dr. Benson was born in Aiken, S. C., July 28, 1861. He was graduated from the Atlanta Medical College in 1882. He was at one time President of the Atlanta Board of Health.

He is a brother of Dr. Marion T. Benson, prominent Atlanta physician. Besides Dr. Benson, he is survived by a daughter, Miss Ruth Benson; a son, Charles F. Benson, Jr., who is studying medicine at Emory University, and a sister, Mrs. C. B. Veal.

## THE ATLANTA GRADUATE SCHOOL OF PHYSICIANS and SURGEONS

ATLANTA, GA.

*Announces—*

### Intensive Courses

SURGICAL DIAGNOSIS AND  
OPERATIVE SURGERY

SURGICAL TECHNIC, DOG  
SURGERY, CADAVER SURGERY,  
AND SURGICAL ANATOMY.

Professors H. R. Donaldson, LeRoy W. Childs, and Associates  
Courses short. Classes limited.

*For Information Address*

### THE PROCTOR

Atlanta Graduate School of Physicians and Surgeons

101 North Butler St., Atlanta, Ga.

# **THE JOURNAL**

## **OF THE**

# **MEDICAL ASSOCIATION OF GEORGIA**

DEVOTED TO THE WELFARE OF THE MEDICAL PROFESSION OF GEORGIA

PUBLISHED MONTHLY under direction of the Council

Volume XIV

Atlanta, Ga., June, 1925

No. 6

## **Original Articles**

### **PRESIDENTIAL ADDRESS\***

**J. O. Elrod, M. D.,  
Forsyth, Ga.**

Members of the Medical Association of Georgia:

I feel that the greatest honor I have ever had conferred upon me was when you selected me to carry the banner of our Association for the past year. I wish to thank you for this honor and to assure you that you could not have conferred it upon anyone in our Association, who could appreciate it more than I do. Gentlemen of the Association I have given my best efforts to try to improve, in every way possible, our organization. I feel that our organization is better today than ever before. We have the largest membership in its history, we have a greater number of County Societies organized than ever before. Every District in the State has a well organized and active District Society. I would not have you think that I feel that I deserve the credit for this improvement in our Association, for without the co-operation that I have had from our efficient Secretary-Treasurer, Dr. Allen H. Bunce and our Executive Secretary, Miss Martha Irwin, and without the support of our loyal Councillors and County Secretaries as well as the efficient Committees which we have had this year, little would have been accomplished.

I have attended the meeting of eight of our District Societies and I attended two meetings of two of our District Societies. Should I count that I attended the eleventh and twelfth districts, who were guests of the first

district at Savannah, Ga., during a three days session last July, I would have visited ten districts. I wish to say for the District Societies that they have had fine attendance and instructive papers, their meetings being equal to a day of any State Association. The interest manifested in these Societies has impressed me that every member of our Association has felt it his duty to give his best efforts for our organization during the past year. I wish to thank each and every one of you for your loyal support and hearty co-operation during my term of office.

### **County Societies**

Gentlemen, I have found that some of our County Societies are making the error of allowing physicians in their county to be members of their County Society and not pay their State dues. Some of the Secretaries have made their reports including names of physicians, as members in good standing of their County Society, but as not caring to pay their State dues. I wish to call your attention to this matter as being a violation of the Constitution and By-Laws of your County Society. We can not be members of our County Society and not be members of our State Association.

Another point to which I wish to call your attention is that quite a number of physicians in the State have an idea that they can send their dues direct to the Secretary-Treasurer of the State Association. Your dues can not be paid this way. They must go through some County Society. If your County is not organized and you do not have enough phy-

\*Read before the Medical Association of Georgia, Atlanta, May 14, 1925.



sicians in it to organize a County Society, then you must be a member of some adjoining County Society.

When you have paid your dues and do not receive your membership card within ten days it is your duty to call on your Secretary to know why, as our present Secretary-Treasurer mails out membership cards on the day the report is received. If the Secretaries would be prompt in sending in their reports it would relieve the State Secretary-Treasurer of a great deal of rush work, which comes in between April the first and the time for our annual meeting. This is important, for unless you receive your membership card by April the first you will not receive the protection of the Medical Defense feature of our Association until you have received same.

#### **County Secretaries**

To those of you who are Secretaries at the present time or who may be at any future time, I wish to impress upon you the fact that you are supposed to remit the dues of each member as soon as collected and not hold same until April the first. The provision in our Constitution and By-Laws that a member must pay his dues by April the first or he is automatically dropped as a member, does not apply to Secretaries remitting to the Secretary-Treasurer of the State Association.

I wish to insist upon the County Secretaries trying to keep a live County Organization. Try to have at least two public meetings a year, of your County Society, with a good full Public Health program. If possible, have some prominent layman and some visiting physician on your program. By having these public health meetings and presenting Public Health programs you will gain the confidence of the populace of your County and they will realize that your Society is not a working body for your own interest but for the good of humanity. These public meetings will benefit each individual member of your Society, so in this way the public will find out who composes your Society and the physician who is not a member of his County Society is soon ignored by the public. This will help you to make and keep your County a one hundred per cent membership county. Your Councillor will appre-

ciate your efforts to make your county a one hundred per cent membership county, and will always be glad to render you any assistance that he can to keep your Society a live working body.

#### **District Society**

Your District Society is a wonderful benefit to the physicians in your District, as a great many of them can attend this meeting who cannot attend the State Association. If you will keep your District Society programs up to the same high standard that you have for the past year, your attendance will be larger each year.

#### **District Secretaries**

To those of you who are or may be Secretaries of District Societies, I wish to say that you should demand of every physician registering at your meetings, his State membership card, before he is allowed to register and enjoy the privileges of your Society. I say this for the reason that I have seen a number of times during the past year, physicians attending District Societies, paying their District dues and enjoying every privilege of the Society, who were not members of their County Society nor could they be induced to join. Let me insist that both the County and District Secretaries help your Councillor all you can to keep your organizations as near perfect as possible.

#### **What Our State Association is Doing for her Members**

1. Our Association furnishes to its members a sixty-eight page Medical Journal that will compare favorably with any other State Journal and is worth the price of our annual dues.

2. Our members receive the protection of our Medical Defense feature. This feature alone is worth many times the price of our dues and could not be procured from an Indemnity Company for several times the price per annum. Some Indemnity Companies have ceased to write this kind of protection and those who still carry it have raised their rates on account of the number of damage suits brought against physicians.

The Committee on Medical Defense in our Association has done wonderful work since the feature was adopted in 1916. From then until 1920 they did not have many suits, but

from the beginning up to date they have had eighty-six suits filed, amounting to \$1,600,000 in claims. Fifty-six of these suits, amounting to \$500,000 have gone to trial and were settled in favor of the defendant. Nine suits have been settled out of court in favor of the defendant. Only one claimant has received any damages since 1916, the amount of which was \$35.00. We still have twenty-three claims pending which amount to \$215,000. I would not have you infer from what I have said that we agree to pay any indemnity, for we do not. We only agree to defend any of our members to the last court of our land.

The only conditions that are required of a member is that his dues have been received by the Secretary-Treasurer of the State Association before April the first of each year. He must also notify the Secretary-Treasurer when a suit is brought against him, giving him all the facts in the case. This information is then turned over to our Attorneys, who investigate the case and if necessary will employ local attorneys to assist them in the case. Our Attorneys are retained by the year and paid a stated salary and are specially trained in this work, so they have an advantage over an ordinary attorney. I have made this explanation, as I found while visiting different District Society meetings during the year, that a great many of our members had never read the back of their membership card and did not know they had this protection.

This feature of our Association is one of our greatest expenses and necessitates our keeping our membership as near one hundred per cent as possible or increase the price of our dues, which I do not think is advisable at this time. The only way for us to have our membership one hundred per cent is for every loyal member to see to it that every eligible physician in his county is a member of his County Society.

#### **What Other State Associations are Doing For Their Members**

Our Secretary-Treasurer has made an investigation of what other state associations are doing for their members and the following is a brief summary:

There are at present forty-six state associations and the District of Columbia, making a total of 47. Of these, 35 have a membership of 2,000 or less. The investigation was limited to these organizations, since it would obviously be unfair to make comparisons with states having a great many more members than Georgia. Questionnaires were sent to the Secretaries of these 35 associations and replies were received from 25.

Group I. In 10 states the annual dues are less than \$5.00. However, only 3 of these states having dues less than \$5 publish an independent Journal for their members and only 4 of these states furnish Medical Defense and only 2 furnish both a Journal and Medical Defense. Both of these states are contemplating an increase in dues this year. None of these states have a full time Executive Secretary. Hence, it seems that for less than \$5.00 it is impossible for a State Association to offer much to its members.

Group II. Nine Associations have annual dues of \$5.00. Seven of these publish state journals. Only three of these having annual dues of \$5.00 furnish Medical Defense and are included in the list that publish a Journal. One, Nebraska, is contemplating an increase of \$1.00 to be added to the Defense fund. Another (Florida), hopes to increase dues to \$10.00 or \$15.00, with the view of employing a full time secretary at a salary of \$5,000.00 a year. Dr. Graham E. Henson, Secretary of the Florida State Association, states, "Do not see how you can do all you do on dues of \$5.00. The "Powers that be" in Florida are going to try and push over an amendment to the By-Laws to increase the dues to \$10.00 or probably \$15.00." Minnesota contemplates a change in their Medical Defense plan, since this Defense is now costing them \$2.00 per member. Another of the states (Washington) having \$5.00 annual dues, charges \$10.00 in addition to annual dues for the sole purpose of Medical Defense. Colorado, while not furnishing Medical Defense to its members, is setting aside \$2.00 per member as a special fund for "education of the Public in Medical affairs." The majority of these states in Group II increased their dues up to the



present amount during the past few years. None of them noted any particular decrease in membership, although, in one state, South Carolina, there was considerable protest when the dues were raised to \$5.00 in 1920 and Dr. E. A. Hines, their Secretary, states that "another increase would cause a revolution."

Group III. In Group III there are six states charging more than \$5.00 for dues. They vary from \$7.00 to \$20.00. Four of these publish state Journals and furnish Medical Defense. One, Wisconsin, with dues of \$9.00, will furnish Medical Defense for an additional fee of \$2.00. In other words, members of the State Medical Society of Wisconsin pay \$11.00 to get their Journal and Medical Defense. However, Wisconsin has a very efficient full time Executive Secretary and is doing wonderful work for its members. Vermont, with annual dues of \$9.00, finds that it requires \$7.00 of this amount for Medical Defense. This is the only state that is contemplating a reduction in dues. Wyoming, with annual dues of \$10.00, finds that it costs \$5.00 of this amount for Medical Defense. Mr. Earl Whedon, Secretary of the State Medical Society, says, "The spirit of co-operation secured by the \$10.00 increase is worth \$100.00 to every man in the State. State Convention saves members hundreds of dollars that it would cost to get the same dope at National Meetings." He states further, "If these gobblers had to travel as we do, sometimes 6 to 800 miles, to get across the State, because we have no North and South Railroad, they wouldn't say a word about \$5.00 a year dues. Our membership is as good and there is much more interest shown than when the dues were \$2.00 a year."

The Arizona State Medical Association, with annual dues of \$10.00, finds that it costs \$7.00 for Medical Defense. The Oregon State Medical Society has annual dues of \$20.00; \$10.00 of this goes to the Oregon Public Health League for propaganda, legislative and extension work; \$2.00 goes to Northwest Medicine, their State Journal, and \$3.00 is set aside for Medical Defense. They

have over \$10,000.00 in the Medical Defense fund and for the first time in their history, a material surplus in the fund of the Society, as well as the League. There was some opposition to the increase in dues but it is becoming less all the time as the benefits are better understood.

Thus we see that the benefits to be derived from the Medical Association of Georgia compare favorably with those of other state associations.

### Vital Statistics

I want to call your attention to some duties we should perform in regard to Vital Statistics, as our carelessness along this line is giving our State some unprofitable advertising.

In 1919 the Model Bill requiring registration of births and deaths became effective, in 1920 our Association requested the State Board of Health to rigidly enforce same. While it may appear to place, in some cases, great inconvenience on the physicians, undertakers and midwives, yet we bear the burdens alike with the profession in every other state in the Union except three, South Dakota, Nevada and Arizona, which have not enacted the Model Bill. In 1922 the Census Bureau made an investigation of our mortality records with the result that more than 90 per cent of the deaths were being recorded and Georgia was admitted to the Registration Area for Deaths.

One of the most embarrassing positions in which a professional man can find himself is to be faced in court by a certified copy of an incorrect record which he has written over his signature. Next to that the most embarrassing position is for a physician to find himself facing a change in his diagnosis at the end of the case or at death, and he is to be pitied. The latter position cannot be avoided in some instances but the former is due to his carelessness.

What is said with reference to the physician individually is equally true of the profession as a whole and our Malaria mortality in Georgia which, according to the records, which were filed with the Bureau of Vital Statistics, show that 57 per cent of our Malarial patients in 1924 died, should be em-



barrassing to every one of us, for we know that this cannot be true. But this is the record which we have to show to those who are seeking homes and manufacturing sites in our state. Our total number of deaths from Malaria was 440 in 1924, which is the lowest number recorded in the past five years. The decrease in deaths from Malaria is due to the intensive Malarial campaign which has been carried on by the County Health Officers during the past three years. This decrease in deaths from Malaria should prove to us how important it is to see that this work is carried on in every county in our State that is infested with Malaria.

The records show that most of the Malaria in our State is below a line drawn from the northern boundary of Richmond County across the state to the southern boundary of Muscogee County. Below this line are 84 counties which compose 60 per cent of the state's area and 80 per cent of the swamp lands of Georgia as well as 47.25 per cent of the population. It is our duty to our state and especially to those living in the Malarial section to see that our State Board of Health is given sufficient appropriation to take care of this work in order to help counties in this section that are not able to bear the total expense of Malarial eradication.

In the Registration Area for deaths, the mortality rate from Diphtheria ran only 10 per cent, while in Georgia last year according to the records the mortality was double that or 20 per cent. Whooping Cough likewise shows a mortality of 45 per cent which, as you know and is in truth, out of the question.

Not only because of the State Statutes, as they have been written, but because of the demand of Medical ethics, we must notify the health authorities of certain contagious diseases and when the patient dies we must write a scientific cause of death on the death certificate. Some of us must have failed to do this, because our Malaria mortality rate, as well as Diphtheria and Whooping Cough are too high.

The Medical Profession of Georgia reported 666 cases of Tuberculosis in 1924, but the death records show 2,610 deaths and to

the chagrin of our profession there were 1,944 more deaths than cases.

As much interested as we are in reducing the death rate from Typhoid Fever, as well as the percentage of mortality, as a profession we had 69 more deaths from that disease last year than we had cases. The percentage of mortality cases in Pneumonia cannot be computed for we filed 2,150 death certificates for deaths from this disease and reported 1,151 cases and the same percentage of cases and deaths was shown in Pellagra for 1924.

These records plainly show that we are not reporting our contagious and infectious diseases, this being true we cannot figure the mortality rate of different diseases in our State. Allow me to insist that in the future we be more careful to report these diseases, as we are receiving cards from the State Board of Health each week, on which to make our reports.

Georgia's death rate since 1922 has been the lowest of any state east of the Mississippi river, which has been one of the greatest recommendations of the state to those seeking homes in the South.

While the physician is required to write the cause of death on the death certificate, he is not obligated, under the law, to file the death record, but he is directly responsible for the registration of a birth within ten days thereafter, and although the death records were found complete in 1922, it was found in 1923, by the Census Bureau, that less than 90 per cent of the births were registered, and Georgia was not admitted to the Registration Area.

This condition renders the infant mortality rate, and in fact, any rate based on the number of births, liable to criticism.

Of the twenty-eight states east of the Mississippi, there are but three which are not now securing more than 90 per cent of the births, the three being West Virginia, Alabama and Georgia.

It is up to Organized Medicine in Georgia to not only comply with this law and to file its birth records, but to see to it that births attended by those physicians who are not members of the State Association and also those attended by mid-wives are registered.

In addition to the necessity of birth and death registration from a standpoint of state pride and Public Health, we owe it to the veterans of the last war to file these records. The Federal Government will not increase the disabled veterans compensation for their new babies until a certified copy of the birth record has been filed with his application papers. In fact, the Federal Government takes this stand in all matters relating to citizenship and pensions.

Our Mortality Records for 1924 show that we had 681 deaths from Typhoid Fever which is an increase over 1923, but a smaller number than in 1921 and 1922. During the past five years the total number of deaths from Typhoid Fever was 3343. During the same period the total number of deaths from Diphtheria and Croup was 1730. Either of these diseases is as loathsome and fatal as Small Pox, the total number of deaths from which during the same length of time was only 70, which might be accounted for by the immunity given by vaccination. We have this same protection from Typhoid Fever and Diphtheria, then why allow our population to be depleted by these dreadful diseases when we have the remedy in our own hands? Let us insist on these protections being taken by our clientele. As we all know the State Board of Health will furnish us Typhoid Vaccine without cost.

It has been quite evident that there has been a slow but steady increase in demand for toxin-antitoxin, especially in counties and cities having full time health officers. Recently the State Board of Health circulated a questionnaire to sixteen county health officers regarding the use of toxin-antitoxin during and prior to 1924. Their replies are analyzed as follows:

Sixteen health officers in Georgia gave three injections of toxin-antitoxin to 6,048 children during the three or four years prior to 1924. Of this number six vaccinated children are reported to have developed Diphtheria. One of these developed one year after vaccination, one eighteen months after vaccination, three five months, and one six months after vaccination. From this rather meager data we would infer that about one

out of every thousand vaccinated may under ordinary conditions or probable exposure develop Diphtheria. The fact that 5,692 children were vaccinated by this same group of health officers in 1924 alone indicates that toxin-antitoxin is increasing in favor. The State Board of Health has succeeded in obtaining a special price on toxin-antitoxin of \$1.25 per 30 c. c. bottle, sufficient to vaccinate ten children three doses each. This price is just half the former price of \$2.50, and should go far toward removing one of the chief obstacles to the general use of toxin-antitoxin; namely the cost.

### Child's Health

In the concrete terms of the Secretary of Commerce Hoover, appearing in a bulletin issued through the American Child's Health Association, "There should be no child in America that has not been born under proper conditions, that does not live in hygienic surroundings, that ever suffers from undernutrition, that does not have prompt and efficient Medical attention and inspection, that does not receive primary instructions in the elements of hygiene and good health." We are told that out of two million children born in the United States last year, 190,000 of them died under one year of age. In our own state we had 2,989 deaths from diseases and conditions peculiar to infancy, we have no record of how many children entered upon the second year of life defective. These defects should be corrected at the earliest possible date, as the strength of any structure depends on its foundation. This being true we must build good foundations in our children that the finished product may be strong in mind and body.

Our Educators are crying for physical corrections. We should give the educator a child that is physically fit, when he is six years old. We should have Medical inspection of all school children at least once a year, and then we would not have the child taking the same grade year after year. In the fifty-second annual school report of Georgia for 1923 and 1924 we have this quotation, "The average cost per pupil per year is \$15.62. The total number of pupils retarded 181,817, this multiplied by the cost



per year would mean \$2,839,981.54, showing the enormous loss in money each year for repeaters." Assuming that lack of opportunity to go to school, short terms, and poor equipment in schools is responsible for one-half of this repeating there would still be \$1,419,990.77 to be accounted for, which, no doubt is accounted for by the physical defects. If this amount of money were spent in the right way for physical corrections, then we would not have these repeaters and would not have spent any more money. The trouble is we have the cart before the horse. Make and keep the child physically fit and we will be able to educate him more thoroughly with less expense.

Mr. W. A. Sutton, Superintendent of the City Schools of Atlanta, has reduced repeating in the city schools by one-half in two years, and his statement is that the physical condition of a child is the prime factor in the child's retardation. He has also reduced this by an intensive health program in the schools together with a dental hygiene program, school lunch and physical defect corrections. According to his program he is saving the City Schools of Atlanta this year \$250,000 on repeaters alone. If this can be done for the city of Atlanta, it can also be done for the State of Georgia.

#### State Board of Health

You have heard the report of our Committee on Public Policy and Legislation, recommending a bill to be brought before our next Legislative bodies asking for an appropriation with a graduated scale of six cents per capita for the first year and an increase of one cent per capita per year until a maximum of ten or twelve cents is reached. Georgia now spends 3.1 cents per capita for health work, Alabama 6 cents, Florida 18.2 cents, South Carolina 9.2 cents and North Carolina 17 cents per capita.

The estimated population for Georgia in 1924 was 3,058,260, therefore 6 cents per capita would yield \$183,405.60. One cent per capita each year thereafter would add about \$30,000 per year.

At the present time our State Board of Health receives only \$100,000 per year and this only appropriated every two years.

With the foregoing program the State

Board of Health, besides the work they do now, could subsidize counties that are not able to maintain full time Health Officers, and in this way develop County Health departments in more counties. At the present time we have only twenty-three counties with full time health departments.

Gentlemen, it is the duty of every member of this Association to do all in his power to see that this bill is put through our next Legislative bodies. For Georgia is looking to our profession for the eradication of all preventable diseases.

Again I thank each of you for your loyal support during my administration as President of our Association and I wish to assure you that it has been a pleasure to serve you, and I trust that I may in the future be able to render some service to our Association.

#### THE ATTRIBUTES OF THE HEART'S ACTION\*

W. W. Jarrell, M. D.,  
Thomasville, Ga.

Attention to the caption of this paper will at once exclude a consideration of the gross and minute appearance of the heart's structure as well as the pronounced pathology accompanying its morbid changes. As a matter of fact only the heart's action as manifested by its functional attributes will be considered.

The difference between a recently dead heart and a live heart can not be determined by the microscope but must be measured by the presence or absence of function. Function is not dependent upon organic perfection. There may be pronounced valvular changes giving rise to alarming abnormalities in sound hearts that still function normally and are fully sufficient to the daily needs of normal life.

Outside of the "movies," a man is not measured by the perfection of his features and the symmetry of his members, but he stands or falls by the functional activity of his mind and by the energetic manner in which his symmetrical members respond to the intelligent impulse. So also the heart

\*Read before the Second District Medical Society, Pelham, Ga., September 12, 1924.



is not measured by the perfection of its anatomy but by the competence of its function.

In speaking of Brutus, Shakespeare said that the elements were so mixed in him that Nature might stand up and say to all the world "this was a man." It is not unscientific to make a critical analysis of the heart's action and thereby obtain a clear comprehension of those "elements" or attributes by which the function becomes manifest. Thus by the consideration of these elements and their relation to each other we can construct an intelligent conception of this theme's meaning. This is no treatise on cardiac disease. It has nothing to do with etiology, pathology or treatment. The Bible says by their fruits ye shall know them. We will consider the fruit of the heart's action and know it by its attributes. The process will be rather constructive than analytical.

Dr. Hunt of Kansas City says in an article in the Journal of the Missouri State Medical Association that the heart muscle has five functions, namely, tonicity, rhythmicity, conductivity, contractility and irritability. The conception is very illuminating and forcefully expressed. We differ in detail with the Doctor and think that it would have been better expressed if he had said the heart muscle has only one function which action is characterized by various attributes. As to the number of these attributes contractility is so allied to tonicity that it might be included with tonicity and thus simplify the enumeration. The same may be said of irritability and conductivity. There could be no conductivity if the nerve elements were not susceptible of stimulation hence irritable. So then we would have the heart action or function, for function is only action at work, characterized by three attributes, to wit, tonicity, rhythmicity and conductivity.

Tone is defined as a normal degree of vigor and tension. Then there is tone to the heart's muscle when it is elastic enough to stretch and vigorous enough to contract. It can speed up and it can slow down. It is responsive to stimulation putting out an

increased function. The tone of the heart muscle is projected into its function. The tone incorporates the resources of the heart. The heart is like a bank. It has its currency on the tile and it has its reserve. In times of stress its reserve is drawn into circulation. When the stress is relieved the reserve is restored and the working force is sufficient. The tone of a bank like the tone of the heart is exemplified in its power to draw on its reserve and no bank and no heart can fail till this reserve is exhausted.

The heart has a very wide area of effort before its reserve becomes involved and it is only when this reserve runs low that symptoms of manifest cardiac weakening become apparent. Then follows cardiac bankruptcy when the muscle is no longer sufficient to the demands upon it. It is remarkable how late it is in this condition before serious symptoms of discomfort are apparent. With the loss of this tone the function has no longer its normal vigor and its tension is failing. The heart is failing and with increasingly lagging effort it strives in vain to clear the slate of its allotted functional effort. Air-hunger which was present only on effort at first now becomes constant. A compensatory acceleration of the respiration is an effort to overcome the oxygen deficit. The heart is endeavoring to substitute a rapidity of rate to compensate for the failing volume. Symptoms of a pulmonary engorgement now are manifest in the form of rales first at the bases and later distributed throughout the lungs. The incident bronchial and alveolar irritation cause a cough and ultimately blood may make its appearance in the frothy sputum that constantly rises to the purpling lips. The engorgement of the portal circulation congests the liver which will present a tender area well below the costal margin. The gastric circulation does not escape and the circulatory disturbance may be mistaken for a gastritis of independent origin. The kidneys become congested and albumin and perhaps blood will be found in the more or less decreased urinary output. There is a fluid retention in the body that may vary

from a slight pitting of the extremities to a marked general oedema. This is a consistent picture found where the normal tone has given way to a dilating and functionless muscle.

It does not make a normal rhythm when the cadence is regular or when the spaces between the beats are equal. This is essential but there is more to be demanded of a normal rhythm. Indeed in the absence of other manifestations mere irregularity of beat means little. The essential of a normal rhythm is that the volume of blood delivered to the aorta should be the same. The cadence of the heart is quickened or decreased by the variation of the time interval between the beats. The shorter this rest period the faster the heart beats and the longer this rest the slower the heart beats. So then the beating time in health remains the same. It is true that a rapidly beating heart delivers less blood with each contraction than a slow one but the volume at each beat does not change till the cadence does. So then, as it were, when the heart is eating faster it takes smaller bites but these small bites do not vary in volume. This is compensatory for if the volume were not decreased when the pulse is accelerated there would be an arterial accumulation that would upset the circulatory equilibrium. When you find that the cadence is regular but the volume of the beats vary you have a heart that is stumbling with irregular steps toward catastrophe. This condition is called the alternating pulse and its presence is premonitive of disaster. Although the ordinary disorders in the rhythm are considered to be due to nerve disturbance yet it is inconceivable that there should be found a pronounced deterioration in the innervation of the heart without a consistent degeneration of its muscle and blood supply. The symptoms that accompany the rhythmic disturbances vary from the innocent premature contractions with varying intensity to the alternating pulse which is as stated a precursor of immediate dissolution. When the rhythm becomes hopelessly disorganized it is only a question of time till the belabored and tiring muscle loses its tone and then

the symptoms of the dilating heart overshadow those due to rhythmic disturbance alone.

In speaking of the conductivity the consideration must necessarily be confined to the nerves of the heart and theoretically the disturbance will be one for the therapeutic electrician alone to consider. However beautiful, the theory may be, this is rarely if ever the truth, for as stated before the relation of the muscle blood supply and nerves is too intimate for any to suffer without its effect on the other. Then too the conductivity is more or less closely allied to the rhythm and it is questionable if there is a logical distinction between them. Yet in the disturbance of the conductivity the volume of the blood delivered does not enter so that the present classification seems imperative. The disturbance of the conductivity of the nerves of the heart has its counterpart in the disturbance in the conduction of the electrical impulses outside the body. You find the counterpart of the grounding of the current and you find the counterpart in the interruption of the current. The classical instance of this disturbance is found in heart block where we find the impulse originating in the auricle being shut off from the ventricle and each beats with a rhythm of its own. Until the ventricle finds its own rate and there is the proper adjustment under the changed circumstances they may be more or less discomfort to the patient but sooner or later life, labor and even comfort will be the part of the sufferer although he will have a permanently slowed pulse. Associated with this condition is a very interesting syndrome described by Stokes-Adams, wherein the patient will be seized with convulsive manifestations usually of the face and upper extremities. The jugular veins pulsate the pulse rate is very slow and there are frequent fainting spells.

In concluding this article the attention would be again drawn to the fact that the heart can only fail through loss of function and there can be no loss of function so long as it has a normal tone, a normal rhythm and a normal conductivity.

## THE TREATMENT OF DIABETES AND USE OF INSULIN\*

Thos. E. Rogers, M. D.,  
Macon, Ga.

This disease was recognized by the ancient Greeks, who gave it the name Diabetes, meaning "Fountain," or "Syphon," but as to the cause and treatment, they had very little conception.

Brunner, in 1682 was the first man to suggest that the pancreas had any connection with diabetes, and he had no idea that any special part of the pancreas had more to do with the causation than another.

About 1869 Langerhans, an anatomist, first found and described these peculiar patches of cells in the pancreas that are now called "Islands of Langerhans," but he had no idea they played any part in the disease diabetes, and it was as late as 1895 when Schafer definitely suggested pathological changes in these islets might be responsible for this disease. After this there were many workers trying to prove or disprove Schafer's theory, and trying to extract the hormone, some from the pancreas as a whole, and some from the islets alone.

In 1920 Dr. F. G. Banting read an article written by Dr. Moses Barron published in November, 1920, issue of *Surgery, Gynecology and Obstetrics*—and with the assistance of a medical student, C. H. Best, he went to work in the laboratory of Prof. McCleod at the University of Toronto and dissected the "Islands of Langerhans" from the pancreas of animals, and from these islands obtained an extract containing the hormone which he named Insulin.

This was one of the greatest discoveries of our age in medicine, and certainly the greatest since the discovery of diphtheria antitoxin, and settled beyond a doubt that these islands play a part in the cause of diabetes. It has proven that this disease is a result of a degeneration, dysfunction or hypofunction of these islands, and placed the treatment of this disease in a class by itself as being one of the most scientific

mathematical problems in internal medicine.

As a result of this hypofunction the cells fail to burn carbohydrate in normal proportions, and this carbohydrate as sugar, accumulates in the blood stream. When this concentration reaches a certain percentage the kidneys undertake to prevent more accumulation, and as a result we have glycosuria. The point at which this occurs is called the kidney threshold, and of course differs in different individuals.

The treatment of diabetes for a long time has been dietetic, but the discovery and use of insulin has made the dietetic part more important than ever before. We must now not only limit the carbohydrates, but know the exact amount of carbohydrates, proteids and fats the patient takes in each twenty-four hours, and further, to get his tolerance, we must know the exact amount of sugar he puts out in each twenty-four hours, and to get his kidney threshold we must know at what point of blood sugar he begins to show sugar in his urine.

The carbohydrate intake is the sum total of 100 per cent of carbohydrates, 58 per cent of proteid, 10 per cent of fat. The tolerance is the difference between his daily intake and his urine output, and to give a patient insulin we figure the difference in his tolerance and his total carbohydrate needed and match insulin against this difference in proportion of one unit of insulin for each 2 grams of carbohydrates. Some will burn more, some less, ranging from one to three. The more severe the diabetic the less carbohydrate he will burn per unit, the milder the more he will burn.

Every case of diabetes is a law unto himself. No two cases have the same tolerance, the same kidney threshold or burn the same amount of carbohydrate with a given quantity of insulin.

In working out a diabetic diet there are several things to take into consideration.

- 1st. His health and strength must be maintained.
- 2nd. He must have enough proteid to maintain nitrogenous equilibrium, and if a child, to promote body growth.

\*Read before the Sixth District Medical Society, December 3, 1934, Macon, Ga.



- 3rd. He must have sufficient fuel in heat units to carry on his occupation.
- 4th. He should be kept slightly under weight for his height and age, yet his food bulky enough to as near as possible satisfy his appetite.
- 5th. The ketogenic-antiketogenic ratio must be such as to prevent acidosis.
- 6th. His urine must be kept sugar free, and his blood sugar as near as possible, normal.

In beginning treatment of a given case there are two recognized lines of procedure, both ultimately working to the same end. Some men work out the tolerance of their patients on what is called a basal diet. They take the present height, weight and age of the patient and from a Dubois standard table and chart, figure out a diet. This diet is a 10 per cent under diet for the patient at this particular time with the patient at absolute rest in bed. While on this diet daily tests for quantitative sugar, acetone and diacetic acid are done on the urine, and blood sugar examinations are done at different intervals during the twenty-four hours. After a tolerance test of three or four days the diet is gradually increased to a maintenance diet, without insulin if possible, if not, with the aid of insulin. There is another class of workers who place the patient on a maintenance diet to begin with, work out the tolerance and then give insulin in sufficient quantity to render the urine sugar-free and the blood sugar normal and then if possible gradually reduce the insulin. This latter procedure probably saves time and is of special advantage to patients who are weak and emaciated.

About the most simple way to figure a maintenance diet is to take your patient's height, age and sex and find the ideal weight, deduct about 10 per cent from this weight, then give your patient about 30 calories for each kilogram 2.2 lbs. of body weight. If he is leading a sedentary life he won't need this much, if he is doing hard work, he will need more, depending on the kind and amount of work he is doing.

Now the next problem is to divide the proteids, carbohydrates and fats in proper proportion.

In adults we give from  $\frac{2}{3}$  to 1 gram of proteid for each kilogram 2.2 lbs. of body weight, in children more.

If he is leading a sedentary life  $\frac{2}{3}$  is enough for an adult; if he is a hard worker he should have 1 gram for each kilogram (2.2 lbs.) of ideal weight. The carbohydrates and fats are then divided into one gram carbohydrate for each 3 grams of fat.

The average well person eats four or five grams of carbohydrate for each gram of fat, but since the diabetic must eat what he needs, and not what he wants, and since fat will furnish him fuel as well as carbohydrate, we change his diet to a fat diet as far as we can do so, and still keep his ketogenic-antiketogenic ratio high enough to prevent acidosis.

To illustrate, take a given case, say a man is 40 years old and his height is 5 ft. 8 in., from the standard actuary table his ideal weight should be 155 lbs, we would deduct 10 per cent, making it 140 lbs. or 64 kilograms, and his occupation requires a fair amount of exercise. We would give him 30 calories for each kilogram, then multiply 30 by 64, his kilogram weight, and we have 1920 calories, the total calories required. Now we are going to give him one gram of proteid for each kilogram, so we will give him 64 grams of proteid. Each gram of proteid yields 4 calories—four times 64 equals 256 calories in proteid. Now subtract 256 from your total calories and you have 1664 calories to be divided into carbohydrates and fat in the ratio of one gram of carbohydrate to three grams of fat. Each gram of carbohydrate yields four calories, and each gram of fat yields nine. Multiply the 9 by 3, since he is to get 3 grams of fat for each gram of carbohydrate, and you have 27 calories of fat for each 4 of carbohydrate. Add the four and you have 31 calories for each division—31 divided into 1664 equals  $53\frac{2}{3}$  or say 54 grams of carbohydrate and three times 54 equals 162 grams of fat. Now we have his maintenance diet. Let us see what his ketogenic-antiketogenic ratio is. 42 per cent of proteid and 90 per cent of fat may be converted into fatty acids, in this diet then his fatty acids might be 26.8 from proteid and 145.8 from fat,

total 172.6. His carbohydrate would be, from carbohydrate 54 grams, from proteid 37.1, from fat 16.2, total 107.3. 107.3 divided into 172.6 gives us a ratio of 1 to 1.6.

It has been found that practically all patients will stand a ratio of 1 to 1.65, and the majority of them a great deal higher, provided, of course, you make your patient burn all of his carbohydrate. Fats burn in a carbohydrate flame, so he must burn his carbohydrate to burn his fat. Patients who have had acidosis previously are not quite as safe on a higher ratio as those who have not, and in these cases I would advise from my limited experience, that you run them on a lower ratio for a while and gradually climb up, watching the blood or urine closely for acetone and diacetic acid.

After you have determined his tolerance, if it isn't enough to burn the needed quantity of carbohydrate, you give him enough insulin to make him burn it. If he needs less than 20 units you may give it in one dose 30 minutes before breakfast or lunch, and let this be his largest carbohydrate meal. Above 20 units I prefer dividing into two doses, and above 40 units I divide into three doses. It is given, of course, subcutaneously. It has been proven that no glandular preparation given by mouth or rectum have any effect on this disease. You want to give as little insulin as possible to keep your urine sugar-free, and your blood sugar normal.

Insulin is a great drug, but its indiscriminate use without proper checking is fraught with danger.

Hypoglycemia is more serious than hyperglycemia. A normal blood sugar is from 80 to 120 mg. per 100 C. C. of blood. When this is reduced below 60, insulin reactions may begin, with symptoms coming in the following order: 1st: Extreme hunger, then weakness, trembling, cold perspiration and chill. If the reduction continues below 40 to 45, convulsions may ensue, followed by death. These symptoms, if they should occur, are very easily and instantly relieved by giving your patient a little carbohydrate, preferably in the form of candy or orange

juice. If it goes on to the convulsion stage, then glucose by stomach tube or intravenously. If no carbohydrate is available, 10 min. of adrenalin will mobilize enough sugar from the liver to tide him over until it can be obtained.

The way to prevent insulin reaction is to keep tab on your blood sugar and as his tolerance rises, raise your diet or reduce your insulin. When you have rendered his urine sugar-free, his blood sugar normal, you have lifted the burden from the overworked, partially exhausted islands that remain. Every patient, unless he has a complete degeneration of his islands, will gain tolerance during the first few weeks of his treatment. I have seen the tolerance grow from zero to 50 and 60 grams carbohydrate in two or three weeks; in others from 30 or 40 to a 100 grams in a month or six weeks. As a general rule the earlier treatment is begun, better are the chances to gain tolerance, and the more closely he observes and stays within his tolerance, the better are the chances to hold it. To abuse it means to lose it.

It is useless to say that every diabetic should have a thorough history and physical examination, and any abscessed teeth, infected tonsils or other foci should be eradicated. It is not unusual in severe cases to find the urine loaded with albumin and casts and have it clear up entirely as soon as you have gotten him sugar-free.

The diabetic should avoid exposure, infections and worries. These things tend to lower his tolerance. He should endeavor to keep his general health at a higher standard than the average individual.

As you already know, it is impossible to treat diabetes without quite a bit of laboratory work, especially quantitative sugar tests on the urine and blood, acetone and diacetic acid tests, and unless you have access to a laboratory, or are willing to take the time to do it yourself, you should not attempt to treat diabetes. Each examination takes only a few minutes of your time and is very easy to do, once you get on to it. There are several methods used, but for

the quantitative urine, I think the Benedict is the one of choice, as to simplicity and time, and for the blood the Folin Wu. However, the outfit for making this one is a little more expensive than the picric acid glucose standard solution. This latter is not quite as accurate as the Folin Wu, but accurate enough for practical purposes. Prussic acid test is used for acetone, and ferric chloride for diacetic acid.

Figuring diets come easy, after you have gotten acquainted with the food values of different foods. You can make out a menu in a few minutes, but there is a task ahead of you that takes some of your time, and yet if you fail in it you have failed in the whole, and that is teaching your patient, for he is the one that has this to do the months and years that are ahead, and the better he understands it the less irksome it is, and the more closely he will follow it. The better teacher you are, the better diabetic doctor you are.

Ignorance is a dangerous thing for the diabetic. You must not only teach him food values, you must teach him diabetic arithmetic. You must teach him how to weigh and measure his food, how to administer his insulin, how to examine his urine, what to do in case of infection, what to do if he develops a diarrhea, what to do if for any reason he is unable to obtain his insulin.

If he never learns anything else in his life, these things he must know, for life itself depends on this knowledge.

#### REFERENCES

- W. E. McCurry, *The Journal of the Medical Association of Georgia*, October, 1924.  
 F. G. Banting, *Beaumont Foundation Lectures*.  
 J. J. McCleod, *Beaumont Foundation Lectures*.  
 E. P. Joslin, *Treatment of Diabetes Mellitus*.  
 Russell M. Wilder, *Medical Clinics of North America*, July, 1923.  
 Reginald Fitz, *Medical Clinics of North America*, November, 1923.  
 Henry J. John, *Surgical Clinics of North America*, August 1924.

## ABDOMINAL DIAGNOSIS FROM THE GENERAL PRACTITIONER'S STANDPOINT\*

William S. Cook, M. D.,  
Albany, Ga.

The attitude of the general practitioner toward abdominal diagnosis should be divided into two facts: First, that abdominal conditions are for the most part surgical; second, that a complete and systematic diagnosis should be made and an operation performed at the earliest possible moment. Recognition of these two undoubted truths will lead to a smaller number of late operations, when interference, however much demanded, is dangerous.

The general practitioner is usually the first to give medical advice in cases of acute and chronic abdominal conditions. He should at all times be on the alert and keep before him a mental picture of the possibilities of the following abdominal diseases:

- (1) Appendicitis.
- (2) Perforative peritonitis.
- (3) Gall-bladder or gall-duct diseases, with or without gall-stones.
- (4) Gastric or duodenal ulcer and hyperacidity.
- (5) Obstruction from hernia, volvulus, intussusception, constricting bands.
- (6) Lead colic.
- (7) Typhoid fever.
- (8) Pneumonia or pleurisy.
- (9) Pancreatitis.
- (10) Acute epididymitis.
- (11) Carcinoma of the abdominal viscera.
- (12) Tubercular peritonitis.
- (13) Renal Colic.
- (14) In women: Acute pelvic diseases, menstrual disorders, and toxemia of pregnancy.
- (15) Acute gastritis and biliousness.

All of these possibilities must be considered in detail if we are to escape the serious mistake of considering a dangerous case as only a slight illness. I sincerely believe that we practitioners will have to answer for more sins in the name of acute gastritis and hyperacidity, and of that meaningless

\*Read before the Second District Medical Society, Pelham, Ga., Sept. 12, 1924.



term "bilious attack" than for any other one or two things in our practice.

Thus I have put acute gastritis and its conferees last because all other conditions must be excluded before we have the right to make the diagnosis of acute gastritis. We may be assured that when the abdominal pain is accompanied by fever, tenderness, and leucocytosis the condition is certainly not acute gastritis.

The blood analysis is an important factor in the diagnosis of abdominal diseases. This analysis should consist of a Wassermann and a Widal serum test as well as a leucocyte count. The making of a leucocyte count is absolutely necessary to insure a correct differential diagnosis. Therefore every practitioner should be able to take the blood with a pipette and dilute it, and send it to the laboratory for a count or examination as indicated by the clinical symptoms. Sometimes a blood count or examination is much more beneficial to the patient than a medicine case.

The first and perhaps the most prevalent of these possibilities as mentioned above is APPENDICITIS. The following are the text-book symptoms:

(1) Abdominal pain: Often this pain is extremely acute, sometimes dull, frequently it is at first general over the abdomen, later it is located in the right iliac fossa. Chronic appendicitis is characterized by irregular and varied attacks of pain.

(2) Tenderness: This symptom is present in appendicitis almost without exception, and is usually greatest over the McBurney point, midway between the umbilicus and superior iliac spine. But remember the greatest spot of tenderness may be high up along the colon, over the gall-bladder region, over the urinary bladder, even on the left side.

(3) Local resistance: Local resistance is felt almost without exception over the spot of tenderness, usually in the right iliac fossa, but always over the tender area.

(4) Vomiting: Vomiting is a frequent symptom in the beginning of the attack. Often undigested food is vomited.

(5) Constipation: This is the rule but

on the contrary there may be loose bowel movements, often dysenteric in type.

(6) Urinary symptoms: Frequent, painful urination, often with blood and leucocytes in the urine. This is when the appendix is adhered to the bladder or in close proximity to all of the pelvic organs.

(7) Leucocytosis: Leucocytosis is almost the unexceptional rule. Sometimes there is a great increase in cells, sometimes there is a moderate increase, but there is always some leucocytosis.

Now these symptoms as stated above are text-book symptoms, which are frequently thought sufficient for treatment. But I want to warn all of my fellow practitioners that they must, even with these symptoms think of the list of possibilities I have mentioned and send their patient to the surgeon as free from error as possible. More will die if we pursue a plan of waiting than if we operate immediately.

PERFORATIVE PERITONITIS: The general symptoms of perforative peritonitis of any viscus are:

(1) General and sudden abdominal pain, sometimes coming on as suddenly as a stroke of lightning.

(2) Collapse.

(3) Tense abdominal walls.

(4) Knees are drawn up.

(5) Pulse and respiration rapid with varying temperature.

The third possibility, as mentioned here, is the DISEASED GALL-BLADDER. Gall-bladder diseases may be differentiated by the location of the pain, tenderness, resistance over the gall-bladder, its radiation to the back. Occasionally there is a mass or tumor in the gall-bladder region. Sometimes there is jaundice, but you must remember that jaundice in a large majority of cases is from gall-bladder or gall-duct inflammation.

Judd, a prominent surgeon of the Mayo Clinic, has classified gall-bladder diseases into four groups:

(1) Chronic cholecystitis, characterized by dyspeptic symptoms.

(2) Gall-stones with colic.

(3) Cholangitis, with stones in the common duct.

- (4) Atypical cholangitis, with painless jaundice.

This same surgeon believes that the evidence in most cases has shown that the normal gall-bladder regulates the flow of bile. However he recommends the routine removal of the gall-bladder in preference to the drainage operation, because the convalescence is better and the ultimate results certainly justify it. He further states that the removal is safe in the hands of the average experienced operator. Judd says that the gall-bladder should be removed when the disease is confined to it, also when the head of the pancreas is enlarged and hard. He reserves the cholecystotomy operation for those cases in which the removal is technically too difficult, and for poor surgical risks.

Many diseased gall-bladders are mistakenly diagnosed and treated as lesions of the stomach.

**GASTRIC or DUODENAL ULCER:** Gastric and duodenal ulcers usually have a symptomatology of their own: hyperacidity, pain recurring long after eating, just when the gastric juice and food begin to flow over the ulcerated area. The pain is not usually severe, on the other hand it may be so violent and acute or so obscure as to cause the diagnostician to hesitate long before attributing them to their proper cause, or the surgeon to advise correct surgery without trepidation. The pain varies from the simplest form of gastritis in which only one or two articles of food disagree to the most severe in which every form of food disagrees. One patient will have severe hemorrhage from the stomach, the other will belch with great force and frequency. The resistance and tenderness are above the umbilicus. There may be occult blood in the stool, but this may not be ascertained at the first visit. There is no leucocytosis in gastric or duodenal ulcer.

**HYPERACIDITY:** I mention this in this place because I believe that many of the supposed cases of simple hyperacidity are in reality gastric or duodenal ulcers, and should not be confused with these diseases.

**INTESTINAL OBSTRUCTION:** A hernia may be present and unknown to the patient. The examiner must look in the groins and the umbilical region for a constricted mass. Usually vomiting is present, and often extremely severe and continuous. There is more collapse in volvulus, hernia, and intussusception than there is in appendicitis. The tenderness may be anywhere over the abdomen. In intussusception there may often be found a mass palpable, more distinct in outline at times when the peristaltic wave reaches the seat of obstruction. There will be regular peristaltic pains gradually coming on, reaching a height of intensity, then gradually subsiding. In all the stages of obstruction these pains are followed by nausea and vomiting, later the vomit becoming fecal in character. There is no leucocytosis.

**LEAD COLIC:** Always look at the gums! A blue line together with a history means lead poisoning. More than one patient has been prepared for operation and the blue line found.

**TYPHOID FEVER:** There is usually a history of illness continuing some time before the attack of pain, but typhoid symptoms sometimes begin suddenly, especially in children. There may be tenderness in the extreme right iliac fossa. There may be a mass simulating the mass in appendicitis. Sometimes there is a true appendicitis with typhoid fever, and there is extreme difficulty in diagnosis, for all the signs of appendicitis are present, including leucocytosis. Hence the presence of a positive Widal and a history of diarrhoea, rose spots, enlarged spleen, make a diagnosis. In uncomplicated typhoid there is no leucocytosis, but often leucopenia.

**PNEUMONIA or DIAPHRAGMATIC PLEURISY:** This condition must always be thought of and looked for in examining for appendicitis, especially during the winter months. If not, the symptoms will deceive the very elect. There is sudden pain, fever, tenderness and resistance in the abdomen with leucocytosis. However, in pneumonia, while the pain is complicated in the abdomen

there is less of the characteristic tenderness and less resistance. I have recently seen a case of pneumonia with resistance as great in the abdominal muscles as in general peritonitis. The respiratory rate is increased. A careful physical examination will usually reveal some abnormality of the lung on the right side. Deep inspiration is checked by sudden pain. The breathing sounds are greatly diminished on the affected side.

**ACUTE PANCREATITIS:** Acute pancreatitis may be extremely difficult of differentiation; there is pain, tenderness, fever or collapse. The collapse is usually more marked than in appendicitis; the tenderness farther up in the abdomen; the epigastrium is frequently extremely tender.

**ACUTE EPIDIDYMITIS (Right Side):** Right sided epididymitis sometimes gives rise to abdominal pain so severe, that an operation may be contemplated. One glance at the testicle will make a diagnosis.

**CARCINOMA of the ABDOMINAL VISCERA:** Carcinoma has a long standing history of ill health. There is frequently a tumor. There is no leucocytosis unless there is an inflammatory condition.

**TUBERCULAR PERITONITIS:** Tubercular peritonitis has also a long standing history. There is distention of the abdomen or marked retraction. The tenderness is general, rather than local, though occasionally the beginning may be represented by severe local pains and tenderness. There is leucocytosis. Usually tubercular lesions may be diagnosed elsewhere in the abdomen.

**RENAL COLIC:** Renal colic on the right side has pain and vomiting. There is bloody urine, when the appendix dips into the pelvic cavity it may give rise to these signs. In renal colic the pain is excruciating and continuous. There is no fever and no leucocytosis. I have seen a case where all of the signs of renal colic were present, at the first visit, without fever or leucocytosis, however in a few hours fever and leucocytosis of appendicitis appeared. Operation proved appendicitis.

**IN WOMEN: ACUTE PELVIC DISEASES, MENSTRUAL DISORDERS and TOXAEMIA of PREGNANCY:** In women

salpingitis, extrauterine pregnancy and appendicitis may closely resemble each other, where the appendix is low or the tube high. In extra uterine pregnancy there is likely to be anemia. A vaginal examination and a history will make the diagnosis. Menstrual disorders should be separated by the fact that there is no fever, no leucocytosis, and by the history of the case. In toxæmia of pregnancy examination of the urine together with a history will make the diagnosis.

**ACUTE GASTRITIS:** After all of the above possibilities have been excluded, one may think of acute gastritis, which certainly does frequently occur. But I beseech you not to be misled. The vomiting of undigested food, the taking of indigestible food, may mean only that this food is the cause of an outbreak of an attack of appendicitis, or gall-bladder disease; and the vomiting, the result. As I said in the beginning, pain, tenderness, fever, leucocytosis mean something other than gastritis. If we are to be just to our patients and to ourselves we must take the precaution. Now after we are convinced that there is appendicitis or inflammation of the gall-bladder, or other acute or chronic conditions; what should we advise? If there is any doubt in the least in our mind as to the diagnosis call in a surgeon and have the benefit of his opinion.

Purging, freezing, and other internal or external medications of any sort, especially morphine, are full of pitfalls and are dangerous to our patients, although purging will sometimes promptly relieve the pain but is apt to produce gangrene or perforation. Ice relieves the pain but we must use it only as a palliative, for the shortest possible time, not for a cure. Use it only when advised by the surgeon. Morphine masks the symptoms. The disease continues insiduously and kills the patient.

In conclusion, I recommend immediate operation as the safest plan. Then, from a practitioner's standpoint, examine your patient, from head to foot, make your diagnosis early and if in doubt call in a good surgeon to help make the diagnosis and operate at once.



## OPAQUE AND NON-OPAQUE FOREIGN BODIES IN THE GASTRO-INTESTINAL AND RESPIRATORY TRACTS

With Report of a Few Cases

J. W. Landham, M. D.,  
Atlanta, Ga.

Patients suspected of having opaque or non-opaque foreign bodies in their gastro-intestinal or respiratory tracts demand the utmost skill of the radiographer, internist and bronchoscopist.

This applies more especially to the management of patients who have non-opaque foreign bodies in their gastro-intestinal or respiratory tracts for the reason that the radiographer has always been able to locate the opaque foreign bodies. The opaque foreign bodies found most frequently in the gastro-intestinal tract consist of safety pins, dress pins, coins, dental instruments, buttons, toys, carpet tacks, etc.

The opaque foreign bodies in the gastro-intestinal tract are usually localized by the radiographer without the aid of the internist or bronchoscopist. (Parenthetically I might state that I am using the term bronchoscopist to apply in gastro-intestinal and respiratory cases.) However, it is frequently necessary to administer a suspension of opaque material before the opaque foreign body can be definitely localized. This has, in a limited number of cases that I have studied, been a decided advantage, both as an aid in their localization and more rapid expulsion.

The long delay that often occurs in the passage of foreign bodies through the gastro-intestinal tract has been attributed to pylorospasm and reversed peristalsis. However, cases studied carefully by means of the fluoroscope in whom metallic foreign bodies had been in the stomach for two or three weeks showed that these phenomena did not exist. It has been observed that these patients passed their foreign bodies normally after taking the opaque meal and that this aid in the passage of the foreign bodies is due to the deposit of the barium sulphate on the flat surfaces and sharp edges of the foreign bodies. Some of the flat foreign bodies have been almost globular in form at the time of expulsion.

Non-opaque foreign bodies in the gastro-intestinal tract are diagnosed and localized by the bronchoscopist with esophagoscope or gastroscope and by the radiographer on account of the obstruction to the passage of an opaque meal. Cases in which there is complete obstruction there will be subjective and objective findings, but localization cannot usually be made by these findings alone. The opaque foreign bodies found in the respiratory tract consist of coins, safety pins, dress pins, tacks, erasers, buttons, etc. These are satisfactorily diagnosed and localized by means of the X-Ray. The opaque foreign bodies in the respiratory tract as a rule give rise to few subjective or clinical findings, and may remain in the respiratory tract for a long period of time before any marked pathology is found. If a main bronchus should contain a foreign body of sufficient size to cause obstruction there would be early clinical findings.

The non-opaque foreign bodies found in the respiratory tract consist of peanuts, watermelon seed, beans and other kernel nuts.

Our knowledge concerning the pathology, clinical and X-Ray findings in these cases is due to the untiring, though fruitful efforts of Doctors Chevalier Jackson, W. H. Spencer and Willis F. Manges of the Jefferson Hospital published in the American Journal of Roentgenology, June, 1920. On account of the marked pathology that soon follows the aspiration of non-opaque foreign bodies, especially nut kernels, into the respiratory tract, it is of the utmost importance that the pediatrician, internist, bronchoscopist and roentgenologist should know the physical, bronchoscopic and radiographic findings in these cases.

The history is very important and should be known by all concerned in the diagnosis and management of the case. An accurate history cannot always be obtained even in adult cases since the foreign body may be aspirated during a period of unconsciousness. However, a presumptive diagnosis of foreign body in the respiratory tract may be made when the parents or nurse inform us that the patient had an object in the mouth and suddenly had a paroxysm of choking and coughing, followed by wheezing respira-

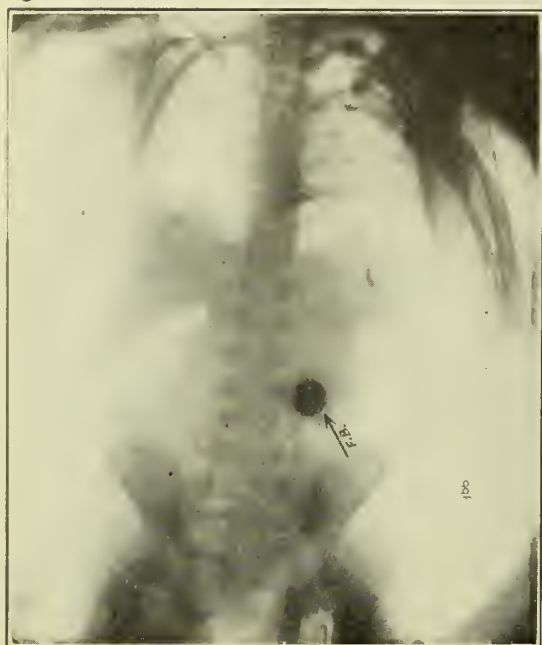


Fig. I. Case 1. Arrow points to opaque foreign body located in the left hypochondriac region. Administration of barium meal showed the foreign body to be in the stomach.

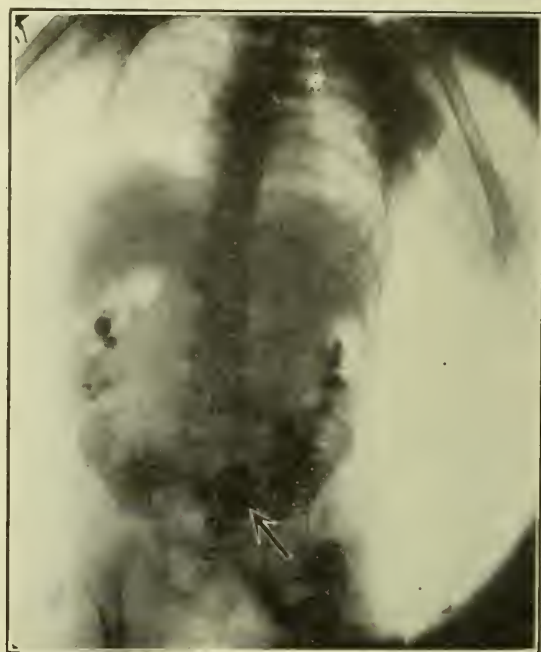


Fig. II. Case 1. Arrow points to foreign body incorporated in a mass of barium sulphate in the region of the sigmoid flexure of the colon. Foreign body passed during the day.

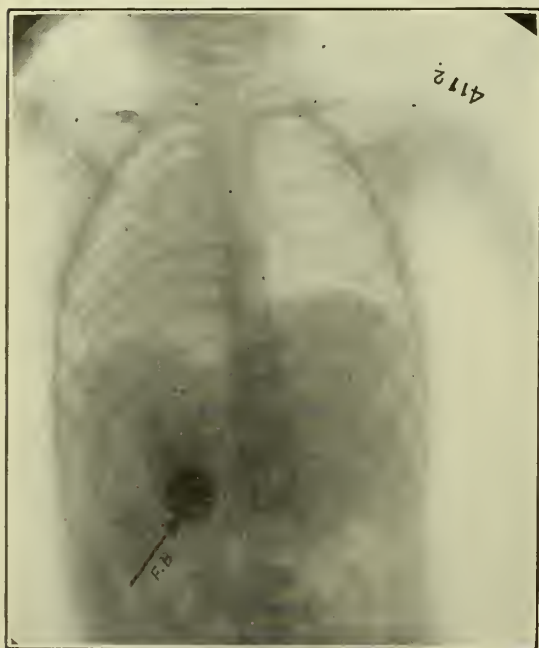


Fig. III. Case 2. Arrow points to metallic foreign body supposed to be located in the esophagus but x-ray examination showed it to be in the left upper quadrant of the abdomen. Barium meal given for purposes of localization showed the foreign body to be in the stomach.

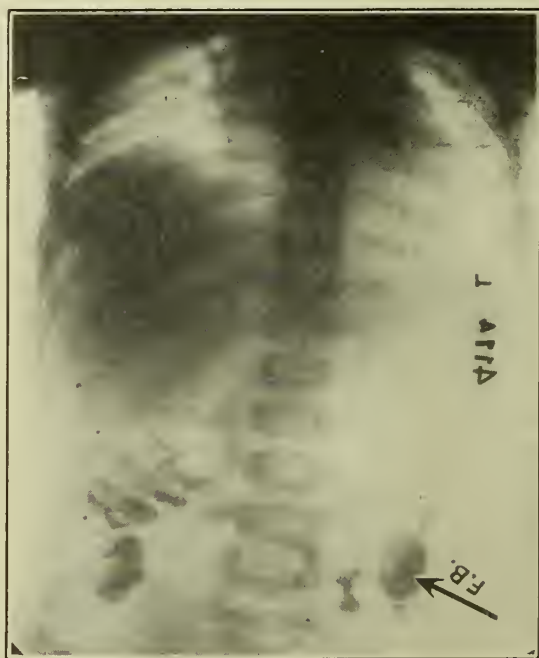


Fig. IV. Case 2. Arrow points to location of foreign body in the descending colon twenty-four hours later. Foreign body well incorporated in barium sulphate passed during the day.

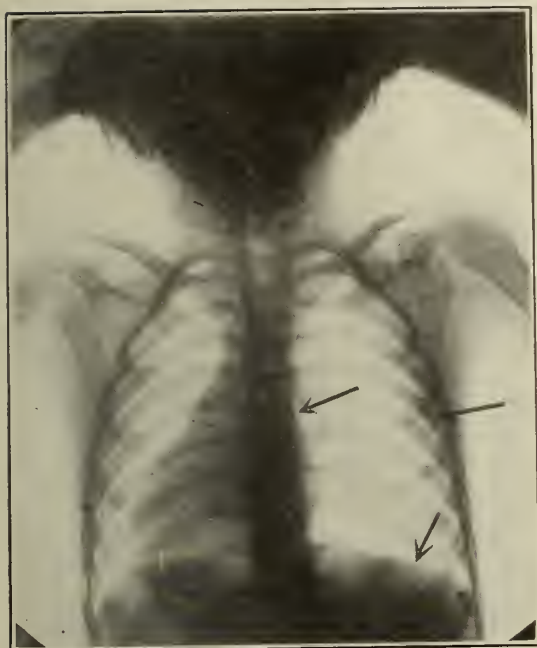


Fig. V. Case 3. Arrows point to invariable x-ray findings of non-opaque foreign bodies in the respiratory tract before lung pathology exists as a complication. Note increased transparency throughout the right lung, displacement of the heart and mediastinal contents from the foreign body and downward displacement of the diaphragm on the right side.

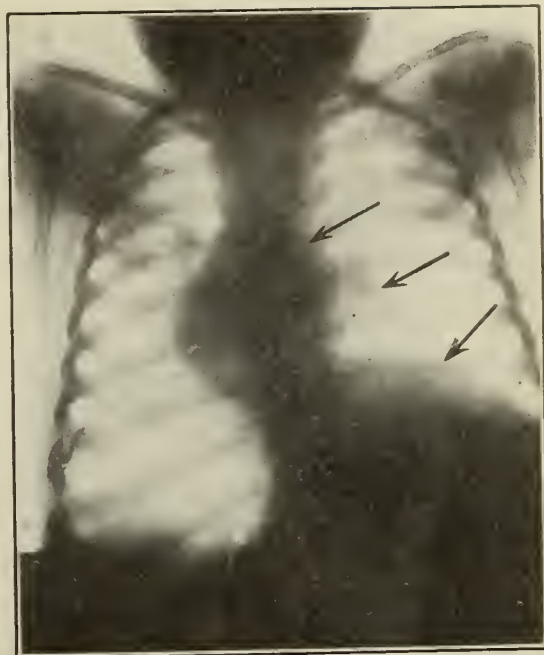


Fig. VI. Case 4. Arrows point to increased density in the right lung due to lung pathology, slight downward displacement of the diaphragm on the right side and displacement of the heart and mediastinal contents to the left.

tion, dyspnea and fever. The physical findings always consist of diminished expansion on the affected side, but other clinical findings vary with mechanical and pathological conditions present. The wheeze referred to as a part of the history has been termed "asthmatoïd wheeze" and is not present when the bronchus is completely occluded by the foreign body or when the area supplied by the obstructed bronchus is filled with secretion.

Percussion over the obstructed side reveals a peculiar impaired resonance which has been compared to the note of a drum which has its air vent plugged. This impaired resonance is not present when the lumen of the bronchus is completely obstructed by the foreign body or the area supplied by the bronchus is filled with secretion. In such cases there will be marked dullness or flatness. Auscultation reveals the breath sounds greatly diminished on the affected side if the obstruction is not complete, but if it is complete or if the area supplied is filled with secretions, the breath sounds will be absent. Harsh breathing with loud, snoring, snapping

and bubbling bronchial rales is heard on the unobstructed side.

The predominating roentgenographic findings are:

1st: Increased transparency on the obstructed side before lung pathology exists. After the bronchi are filled with secretions and other lung pathology is present there will be increased transparency on the unobstructed side.

2nd: Depression of the diaphragm and limited diaphragmatic excursions on the affected side.

3rd: Displacement of the heart and mediastinal contents toward the unobstructed side.

Case No. 1. Male, white, aged 3 years, referred for X-Ray examination July 10th to determine the presence of foreign body swallowed two weeks previously. X-Ray examination showed the presence of a conduit cap in the upper left quadrant of the abdomen. X-Ray after the administration of a barium meal localized the foreign body in the pyloric end of the stomach. In the morning of the following day the foreign body was found in the sigmoid flexure and was evacuated later the same day.

Case No. 2. Female, white, aged 2¼ years, referred for examination April 17th, for suspected foreign body in the esophagus swal-



lowed more than two weeks previously. X-Ray examination at 11 A. M. showed the presence of a coin, apparently a nickel, in the upper left quadrant of the abdomen. Barium meal given at 4 P. M. the same day for the purpose of localization showed the foreign body to be in the stomach. At 11 A. M., April 18th, X-Ray examination showed the coin to be in the descending colon just above the crest of the ilium, and it was evacuated during the same day.

Case No. 3. Female, white, aged 4½ years, referred late in the afternoon of August 23rd for X-Ray examination for suspected non-opaque foreign body in the respiratory tract. Early in the afternoon while the child was eating watermelon it had a sudden paroxysm of choking and coughing and soon developed wheezing respiration and other physical signs of a foreign body in the respiratory tract. X-Ray examination consisting of fluoroscopic and film studies showed inhibited diaphragm excursions on the right side, increased transparency of the right lung and slight displacement of the heart and mediastinal contents toward the left lung. Upon these findings a positive diagnosis of a non-opaque foreign body in the main right bronchus was made. The child was bronchoscoped that night by Dr. Equen and a watermelon seed was removed from the main right bronchus.

Case No. 4. Male, white, aged 6 years, referred for X-Ray examination April 11th for suspected non-opaque foreign body in the respiratory tract supposed to have been inhaled about three weeks previously. The clinical findings indicated the presence of a foreign body with probable pathology in the right lung. X-Ray examination showed decreased transparency on the right side due to the presence of secretions in the bronchi, diminished excursions of the diaphragm, and displacement of the heart and mediastinal contents toward the left lung. Upon these findings the child was bronchoscoped by Dr. Buff and a peanut hull removed from the right bronchus. The lung contained much secretion and pneumonia was developing.

#### COMBINED GASTRIC AND DUODENAL ULCER

In approximately 7,500 roentgenographic examinations of the gastro-intestinal tract in the last three years, Jacob Buckstein, New York (Journal A. M. A., May 2, 1925), has seen only three cases in which both the roentgen ray and surgical exploration demonstrated the presence of a combined gastric and duodenal ulcer in the same patient.

#### BRONCHIAL SPIROCHETOSIS—REPORT OF CASES

Eugene E. Murphey, M. D.,  
Augusta, Ga.

Within the past two years, we have been able to identify on the medical wards of the University Hospital several cases of bronchial spirochetosis; the case histories of three of which I desire to present to you this morning.

This disease was first described as a definite clinical entity by Castellani in 1906. It has been reported as existent in most old world countries and particularly from those countries bordering the Indian Ocean. The disease may appear in either an acute or chronic form, is attended by irregular fever, not infrequently associated with night sweats and definite loss in weight.

Obviously a chronic febrile disease attended by a cough, hemoptysis, bronchitis, and emaciation, would call at once to the mind of the examiner the probability that he was dealing with pulmonary tuberculosis, and even careful and accurate clinical observers may be misled into diagnostic error unless the possibility of this disease is kept constantly in mind. It is with the view of aiding you to eliminate this possibility of error that these histories are brought before you and their import stressed. It is a serious thing, both from a professional and an economic viewpoint, to announce to a patient that he has pulmonary tuberculosis and that he must devote the necessary months or years to the arrest and cure of the infection, when he is in fact suffering from a disease which is quite different and which needs no such regimen or care. Recovery seems to be the rule in these cases, although we have a record of one case terminating fatally in this hospital. The most characteristic feature in the cases which I have seen is the association of marked fetor of the breath with muco-purulent or even watery, blood stained or blood streaked sputum, which in the typical cases is almost characteristic, in that the blood seems to be hemolyzed, giving to the mass after standing a uniform raspberry color, quite different

\*From the Department of Medicine University of Georgia. Read before the Tenth District Medical Society Nov., 1924.

from the hemoptysis of tuberculosis or the rusty sputum of pneumonia.

Two of our cases, one of which I am reporting today, and another not included in this report, have shown skin lesions somewhat resembling but quite different from those of pellagra; but to what extent skin lesions occur as a definite part of the symptom-complex of this disease I do not know, nor is such of the literature on the subject which is available to me at all enlightening on this point.

The physical signs are those of rather coarse bronchitis perhaps associated with bronchiectasis; particularly might we expect to find the latter in elderly individuals in whom this infection has run a chronic course and persisted for a considerable period of time. In fact, I may say in passing, that the thing which impressed me with these cases when I first saw them was that although they were running a febrile course, had hemoptysis and had lost considerable weight, the physical signs on auscultation of the thorax were not those of the pulmonary tuberculosis which I reasonably expected to find, but were instead those of a generalized bronchitis. Examinations made at repeated intervals for tubercular bacilli were negative but the sputum was found to be loaded with spirochaetae which stained vividly with dilute carbol-fuchsin.

Mr. H. L.—Case History 8541—Admitted to Hospital Feb. 8th, discharged Feb. 11, 1924.

Feb. 8, 1924. C. C.: Cough with hemoptysis.

P. I.: Born and raised in McDuffie County, married 15 months ago; moved to Atlanta one year ago. Health was excellent at that time. Worked in a printing establishment where he was closely confined. Took little exercise and was but little out of doors. Developed a cough 7 or 8 months ago which has persisted. Thought little of cough at first but about a month after its appearance he began spitting up blood after coughing. During the next 3 months he became slowly worse. Lost about 10 pounds. Three months ago he returned to the country, upon a doctor's advice. Since then he has shown steady improvement and has regained weight and appetite. Sleeps irregularly. Has had night

sweats and afternoon temperature (100) since onset of present illness. Formerly had pain just inside right nipple after coughing which has been hardly noticeable for past month.

Usual childhood diseases. Pleurisy in babyhood. Influenza five years ago.

F. H.: Mother died two weeks after labor, puerperal sepsis. Father and six brothers living and well. One sister died of LaGrippe.

### Review of Symptoms

Head: Headache occasionally. Had not been subject to colds or sore throat prior to P. I.

E. E. N. & T: Negative.

Has severe dyspnoea on exertion; sometimes has dyspnoea on lying down. No edema. Appetite good at present. Digestion good. Bowels regular. No hemorrhoids. Left hernia in infancy. Spontaneous cure. Has had abdominal pain on either side almost constantly since operation for appendicitis 15 months ago.

G. U.: Negative.

Habits: Does not work now—is trying to conserve strength.

### Physical Examination

B. P: 105-60.

General: White male 19 years old, lying quietly in bed. Walked to hospital and does not look ill. Suffering from an infrequent cough productive of blood stained sputum.

Head: Negative.

E. E. N. & T.: Pupils equal regular and react to light; sclerae and conjunctivae negative. Ears, negative. Nasal septum deflected slightly to left. Teeth in excellent repair. Tongue clean. Tonsils are not enlarged but are ragged. No bleeding point seen in mouth, nose or throat.

Thorax: Chest wall symmetrical thick and well muscled. Excursions limited on both sides. Diaphragm descent good. Heart not enlarged; sounds are of good quality; no murmurs. Can demonstrate no lung pathology even in face of a very definite history of right lung involvement.

Abdomen: Scar of gridiron incision. Tenderness in hypo-chondrium. Right inguinal ring relaxed, otherwise negative.

G. U.: Negative. Glands. Negative. Extremities negative. K. K. Sluggish.



X-Ray: Peribronchial infiltration.

Impression — Pulmonary Tuberculosis.  
Right post operative abdominal adhesions.

Wassermann—Negative.

Dismissal Note: Dismissed by Dr. Murphy. No tubercle bacilli found. Dr. Murphy's impression is "Bronchial Spirochetosis." Not improved by stay in hospital.

2-10-24: Smear of sputum stained with dilute carbol-fuchsin shows innumerable spirillae.

2-8-24: Blood positive. No T. B. found.

2-9-24: No T. B. found.

2-10-24: No T. B. found.

R. H.: Case History 8951—Admitted to hospital Feb. 18; dismissed March 15.

February 18, 1924: Patient had influenza four and one-half years ago; mother died with same disease at that time. Patient was ill for one month. Left with a chronic productive cough that has persisted since. Worked until Christmas, at which time he stopped to go to school. Has been decidedly worse since then. Cough is much worse at night; is quite productive, interferes with sleep. Appetite poor. For past two weeks has vomited at night from severity of cough. Has coughed up small amount of blood in past. Since Christmas has noted some blood in stools. Bowels irregular. Has lost much weight in past two months. Some night sweats. Encrusted sore on chin for two weeks. Has to urinate four or five times during night. Inability to hold water long. Father, five sisters and one brother all have chronic coughs, but all are up and about. No luetic history. No venereal disease. Has pain on coughing in left lower thorax.

#### Physical Examination

B. P.: 128-80.

Negro, male, 15 years old, lying quietly in bed. Poorly developed and nourished. Signs of marked loss of weight; skin rough and dry. Encrustation size of quarter on under surface of chin exudes purulent serum. Ears and Nose negative. Teeth, few cavities, gums bleed easily in places, beginning pyorrhea. Tonsils not enlarged but surface is ragged. Eyes, normal. Thorax, breathing largely diaphragmatic, retraction both apices. Im-

pairment percussion note both apices posteriorly. Respiratory Ronchi both middle segments posteriorly. Many coarse bubbling rales over both lungs generally. Musical rales both bases and middle segments. Breath sounds harsh throughout. No areas of tubular breathing or pectoriloquy. Heart not enlarged; no murmurs. Sounds rapid and regular, approach foetal rhythm at apex. Abdomen: Holds muscles tensely so that palpation is difficult. Tympanitic throughout. Inguinal rings negative. G. U. Negative. Extremities, negative except for emaciation. Reflexes K. K. exaggerated—Babinsky—absent. Glands, Right epitrochlear enlarged. Impression—Bilateral Pulmonary Tuberculosis. (Interne's note.)

February 19, 1924: Patient rather poorly nourished and developed, about 15 years of age, lying quietly in bed, giving history of chronic cough, pains in chest and spitting up blood with loss of weight for seven or eight months. Head, negative; eyes, negative; teeth, good; tongue, coated; throat, negative—sore just under chin. Thorax, very poor expansion, especially upper segments of chest. Lungs, impaired resonance both uppers anteriorly and posteriorly with harsh breath sounds. Prolonged expirations and few rales. Squeaking musical rales over entire chest both inspiratory and expiratory with prolongation of expiratory sound. Heart not enlarged; sounds of fair quality, no murmurs.

Abdomen: Liver and spleen negative; no masses. Extremities—Vaccination left arm. Impression: (1) Pulmonary Tuberculosis—Bilateral. (2) Bronchial Spirochetosis. (Resident's note).

Sputum: Muco purulent with streaks of blood; foul odor. No T. B. organisms found. Smear loaded with spirochetes and fusiform bacilli.

X-Ray: Examination of chest—Bilateral peribronchial thickening with bronchiectasis of both lungs.

#### Notes

2-19-24: Slept better than usual last night; coughed less—Sputum examined—No. T. B. found.

2-20-24: Sputum examination negative for T. B.



2-21-24: Sputum examination negative for T. B. Dr. Murphey's clinical opinion is that patient has not tuberculosis but a chronic bronchitis caused by spirochaeta bronchialis. This based on coarseness of rales, X-Ray findings, negative results for T. B. in sputum examinations and the findings of many spirochetes in sputum.

2-22-24: Sputum examination negative for T. B.

Impression of tuberculosis abandoned for following reasons:

- (1) Cleanness of lung parenchyma in X-Ray.
- (2) Bronchiectatic cavities in X-Ray plate.
- (3) Coarseness of rales heard and their general distribution.

(4) Failure to find tubercle bacilli and the presence of numerous spirochaetae demonstrated in smears by dark field illumination.

Impression: Bronchiectasis—Broncho-Spirochaetosis. (Interne's note.)

Wasserman—Negative.

3-15-24: Dismissal Note: Patient dismissed by Dr. Lee. Temperature has been normal for two weeks. Cough greatly improved. Has gained in weight. Urine has almost entirely cleared up. W. B. C. 19,000. Still has coarse rales about bronchial tree.

J. W. G.: No. 10,575. Age 32, Machinist. Admitted Nov. 8, 1919 (surgical). Complaint, pain in right side, cough, weakness, shortness of breath.

P. I.: Onset about September 25th with pain in right side and slight cough. These became worse gradually and after about two weeks were associated with "feverish" feeling. Patient remained at work up to ten days ago, when pain, dyspnoea and cough became so severe that he took to bed. Has had night sweats for the past week. Sputum has been thin and foul for past two weeks. There have been no chills.

F. II.: Unimportant with reference to present illness.

P. H.: Measles, mumps, pertussis and pneumonia in childhood. No other illness up to P. I.

### Review of Symptoms

Negative with reference to present illness. Has lost about 8 pounds since onset of illness.

P. E.: Temperature 101.2. Pulse, 128. Respiration, 28.

A pale, poorly developed and rather emaciated man lying propped up in bed, dyspnoeic, cyanotic and coughing at frequent intervals, expectorating thin frothy brownish sputum which has an extremely penetrating putrid odor.

Head: No noteworthy abnormalities. Eyes, extraocular movements normal. Right pupil larger than left, both round and react to light and distance. Nose, negative. Mouth, lips show dusky cyanosis. Teeth in wretched condition. Tongue, coated; slightly tremulous. Pharynx injected.

Neck: Vessels engorged, otherwise negative.

Thorax: Right side larger than left with obliteration of intercostal grooves over lower 2-3. Respiratory mobility abolished. On palpation, percussion and auscultation there are the signs of a massive pleural effusion occupying the lower 2-3 of the right pleural cavity. The left lung is hyperresonant on percussion. Fremitus is well felt throughout. The breath sounds are puerile with innumerable small and medium moist rales throughout, most numerous at the base behind.

Heart: Displaced to left, P. M. I. diffuse in 5th and 6th left interspaces 4 cm outside midclavicular line. No shock or thrill. Sounds are snapping with systolic murmurs at mitral and pulmonic areas. P2 accentuated.

Abdomen: Flat, slight fullness in right hypochondrium where the edge of the liver is felt 2 f.b. below the costal margin in the nipple line. No other enlarged viscera and no masses felt.

Extremities, negative. Reflexes normal.

Blood examination: W. B. C. 20,600, R. B. C. 4,200,000, Hb. 80 per cent. Urine, negative.

Nov. 9: Right thorax aspirated. 800 c.c. of a thin brown turbid horribly offensive fluid withdrawn. Smears from this fluid showed a few polymorphonuclear cells, occasional mononuclear cells and very many coarse spirillae.

Nov. 11: Surgical drainage of right pleura. Rib resected. 26 ounces of fluid, similar in

all respects to that obtained on tapping, removed.

Jan. 18, 1920: Wound healed. Patient discharged.

Comment: Convalescence was stormy; the cough and expectoration gradually improved after operation, but patient ran a septic fever, with daily peaks varying from 99 to 104, which gradually subsided to normal on January 4.

Second admission: Feb. 17, 1920. No. 17833 (Surgical).

Three weeks after discharge the cough returned, with a great deal of expectoration, which was more profuse when patient lay on right side. The character of the sputum was the same as before. Fever and sweats have become troublesome during the past week.

Temperature 101, pulse 108, respiration 24.

General appearance much better than on first admission. There is slight clubbing of the fingernails of both hands. Physical examination shows signs of thickened pleura over the lower one-third of right chest and rather confusing signs over the left base, consisting of slight dullness, increased vocal fremitus, puerile breathing and very many moist rales of all sizes.

X-Ray at this time showed thickened pleura at right base; on the left there was a small indefinite shadow in the left lower lobe. The bronchi in the lower lobe seemed much larger than usual.

A rather extensive exploration of the right pleura was done in the hope of finding pus. None was found. The operative wound closed by first intention. No blood or sputum examinations were made.

Fever persisted, a septic curve with occasional peaks reaching 103. The patient was discharged March 20, 1920.

Third admission. (Surgical). No. 18462.

April 6, 1920: Operation wound on right broke down yesterday and discharged pus.

Temperature 102, pulse 120, respiration 30.

Draining sinus at level of right 9th rib in axillary line. Signs of fluid at left base. W. B. C. 23,000.

April 7: Trochar and catheter drainage of right pleura. 12 ounces of thick white pus obtained. Dakins irrigation with tube left in.

Condition became steadily worse. Cough was distressing, dyspnoea marked and sputum was abundant and very foul. Temperature septic, peaks of 104.

April 17: Surgical drainage of left thorax, trochar and catheter method. 20 ounces of thick brown stinking fluid removed. Smears from this fluid showed very many spirillae.

Smears from sputum showed innumerable spirillae.

April 22: Left pleura again drained. 16 ounces of the same sort of fluid obtained.

Following this last drainage there was a marked temperature reaction, rise to 104 followed by fall to 96.

Signs over left back in intrascapular region suggested a medium sized cavity.

Patient died April 25.

Pulmonary spirillosis with multiple small cavities in both lungs and bilateral pleurisy with effusion.

Treatment: As most of these cases tend to recovery, the treatment has in the main been largely symptomatic; but we must not lose sight of the fact that the chronic cases do become rather wretched objects and must inevitably be not only quite miserable themselves, but also rather disgusting to those who have to come in intimate contact with them, and that fatal results may in small percentage of cases supervene. It is also quite probable that the disease is directly transmissible from individual to individual, and that some method of isolation should be instituted or carried out. In one of the cases which I am reporting, one brother and five sisters of a patient are all reported as having a chronic cough, the etiology of which was not established, but is quite conceivably due to the spread of this infection throughout the family.

Bearing in mind the well-known spirochetal action of arsenic, one would expect that the arsenical preparations administered intravenously would be the medication par excellence in these cases, and such has been our experience.

It might be well to use the combined Salvarsan-Calcium Therapy as suggested by Pick, who employs in non-tuberculous Pulmonary Disease five or more injections of 0.3 gm. Salvarsan in 10 per cent sterile solution

of pure crystallized Calcium Chloride, believing "that the anti-infectious component of the salvarsan is apparently increased by the combination and the toxicity of the salvarsan decreased."

In conclusion, I merely desire to re-emphasize the fact that this infection is apparently endemic in this section of the country, and probably throughout the entire South, to what extent it is impossible to predicate until its existence becomes a matter of common medical knowledge and its recognition a matter of course by all intelligent physicians.

Until this time occurs, we should at least be on our lookout, quickly to recognize this condition when it confronts us, and to spare our patients the loss of time, the mental perturbation and the physical distress incident to our making an erroneous diagnosis of tuberculosis under conditions which are particularly well adapted to lead us astray.

### CHILDHOOD TUBERCULOSIS AND ITS RELATION TO THE TUBERCULOSIS PROBLEM\*

Edson W. Glidden, M.D.,  
Alto, Ga.

"Hear now a song—a song of broken inter-  
ludes  
A song of little cunning, of a singer, nothing  
worth.  
Through the naked words and mean  
May ye see the truth between  
As the singer knew and touched it in the ends  
of all the earth."

We should begin our attack upon tuberculosis not in the adult but during childhood, when the disease is in the truly incipient or beginning stage and the outlook is favorable. By the time the disease has reached the point where it is demonstrable in the lungs of the adult, it is no longer in the incipient stage and is no longer so favorable.

It is now generally accepted after considerable study that childhood is the period of life in which infection occurs and the disease gains a foothold. There are three general types of tuberculosis as considered from the standpoint of period of life:

1. The infantile type—found under two years of life and is nearly always fatal and usually manifested as a generalized infection.

2. The juvenile type—found usually between the ages of 5 and 12—essentially glandular in type, limited almost entirely to the lymphatic glands. Especially the cervical and hilus glands. In this type fatality is low.

3. The adult type—here we have the disease spread beyond the lymphatic glands and may attack any organ of the body, most conspicuously the lungs, and form the bulk of the cases seen and treated in Sanatoria.

Of course, these three classifications have not rigid limits to these periods of life but may be found at other periods. Pulmonary tuberculosis alone is rarely seen in early childhood and generalized tuberculosis is relatively rare in adults. Truly incipient tuberculosis is really a disease of the lymphatic glands and includes the so-called pre-tuberculous child of which we heard so much a few years ago. In all probability these children, or at least a large percentage of them, should be classified in light of present knowledge really as incipient tuberculosis. The outlook for controlling tuberculosis of the glandular or juvenile type is better than it is in the adult type. Here Sanatorium treatment would be of greater service in the crusade against the disease. Consequently it is seen that our efforts should begin with the child. It is at this period of life that the State would get greatest value for money spent; here, that the various tuberculosis agencies could get best results and save for the State, nation and posterity its potential manhood and womanhood.

How are we to find the tubercular child before the disease has taken too strong a hold? By special examinations for:

1. Children who are 10 per cent or more below accepted standard of weight and height for age.

2. Contact cases—tuberculosis in their homes.

3. Those children whose physical condition is considered below par by teachers and family physicians.

\*Read before the meeting of the 9th District Medical Society, Gainesville, March 18, 1925.



These examinations should consist of careful history taking and examination by physicians skilled in the difficult field of tuberculosis in children, and checked by X-Ray.

Dr. Eugene Kelly, Commissioner of Health of Massachusetts (from whose writings I have drawn freely for this paper) states that 15 per cent of the school children of Massachusetts between the ages of 5 and 12 will be found to come within one of the three groups just mentioned. This would make for the State of Massachusetts 90,000 children who need to be examined, diagnosed, and classified, and for whom appropriate treatment should be instituted when necessary. Based upon comparative population statistics, this would mean that 66,000 of the school children in Georgia would need the same attention. Eight to ten per cent of these below par children of this group will show signs and symptoms sufficient to justify a positive diagnosis. In other words, 5,300 children in Georgia between the ages of 5 and 12 ought to be found and placed under good hygienic conditions and their nutrition improved before they reach the critical period of adolescence and become the much more serious and fatal adult type. In all probability 1 per cent, or 53 of these children, need active Sanatorium treatment—the remainder might be treated at home and returned to health by proper feeding, open air schools, etc. The suspicious cases could be treated at home temporarily but listen to me, my Medical Brethren, 53 children in Georgia need Sanatorium treatment NOW, because they have active glandular tuberculosis NOW. This number, 53, is probably low because of some conditions in Georgia not existing in Massachusetts. To the everlasting shame and discredit of Georgia, there is not a single bed provided for the care of these little ones. There is a hospital in Georgia, not supported by the State, for the care of crippled children, but it is small and not equipped for, and should not be expected to care for glandular tuberculosis. There is not a bed proper, for the care of these kiddies—your Sanatorium cannot take them, they have not the beds nor the facilities. We take a few each year and do the best we can for them, but it is a mighty poor best.

The mortality, aye, the morbidity from tuberculosis would soon be reduced had Georgia a children's building at the Sanatorium where this type could be treated. One of my fondest hopes is that some day we will have such a building, that we will have a staff large enough that we may institute a field service to help examine the three classes already mentioned and speed their hospitalization and cure.

General Pathology: Ghon believes that the portal of entry of the tubercle bacillus is through the lungs, whence it travels to the lymphatic glands at and about the hilum, maybe leaving some microscopic traces, but healing at the point of entry, only to light up into a lesion in the lymphatic as outlined. Even if the primary focus of infection from the pathologic point of view may have been the lungs, the important fact remains that in children the first tuberculous lesion that the clinician can demonstrate is most frequently found in the lymph nodes and tissues of the hilum. As already stated, in children under 5 years of age, tuberculosis is usually of a general type. As found between 5 and 12 it is first found in the lymph nodes. It may involve the lymphoid tissue that is in close contact with the branches of the bronchial tree and later produce lesion in the adjacent tissue. It rarely involves the apices, but when this does occur, we have the adult type of pulmonary disease. This type of tuberculosis is the key to the problem and of infinite importance.

DIAGNOSIS—Symptoms: We must remember that from unhealed lesions toxins are given off intermittently, and that symptoms will fluctuate in occurrence and degree of severity from time to time.

Local symptoms: Frequent colds, cough, hoarseness—but often all local symptoms are entirely absent, and when they appear they are usually transitory.

Constitutional symptoms: Malnutrition, loss of weight, lack of usual normal gain in children has the same significance as loss of weight in adults, and is usually indication of disease. When the child has failed to gain for several months, and there is no morbid condition to account for it, tuberculosis is almost safely suspected as the cause. Palor

frequently is an accompaniment of the emaciation or lack of normal gain even though the blood examination may not show a definite anemia picture. Nervous instability is not infrequently seen. Musculature is flabby and the posture shows evidence of muscle fatigue. Lack of endurance the child cannot keep up with its school work even though he may be perhaps brighter than his fellows, there being the lack of stamina. Fever—a child's temperature fluctuates between 98.5 and 99.8, above these limits explanation must be sought if no cause can be found, tuberculosis is to be seriously thought of. Night sweats may be present but are often absent. It may be borne in mind that sweats in children are often seen and have not the same significance as in adults. These sweats in tuberculosis must be free and are usually seen late in the night.

Cough: There is no characteristic cough of tuberculosis in childhood, but is often brassy in type; there may be no cough at all. Persistent cough for 5 or 6 weeks requires investigation. There is a tendency for this cough to be paroxysmal, resembling that of whooping cough, and often followed by vomiting. Expectoration is not to be expected. The child may have some, but oftener than not swallows it and the occurrence is denied by the mother. Dyspnea is a later symptom, usually. Hemoptysis is rare. Cervical adenopathy and tracheal adenopathy are the most frequent. The cervical glands are enlarged, show less tendency to caseation and suppuration than non-tubercular glands, are less tender as a rule, usually larger and more persistent. Of great importance is the enlargement of the supra-clavicular glands which drain the parietal pleura. Size of the glands may vary from time to time and with this, variation in symptoms. Tracheo-bronchial adenopathy: may be difficult to demonstrate. Physical signs hard to elicit. Inspection may show the hilus dimple of Stoll, which is seen in the second I. S. at end of inspiration. There sometimes may be seen the "saucer" depression posteriorly. The superficial veins over the upper part of the chest may be enlarged.

Paravertebral dullness may be elicited, by careful percussion, the plexor and pleximeter must be smaller than is used in the adult

chest. Exemplify. Percussion must be light. Bronchial breathing over the side of the sternum or in the interseapular space posteriorly. Breath changes about the bronchus may be feeble.

D'Espine's sign: Intense whispered voice heard below the 3rd dorsal vertebra is considered by many as abnormal and indicates the presence of enlarged bronchial glands. These glands may or may not be tubercular. This sign value is disputed by some good observers.

Eustace Smith's sign is of doubtful value.

Roentgen findings are of considerable value and it is upon them that much of the diagnosis may depend. One or more of the following conditions may be found:

Prominent bronchial trunks with a definite beaded appearance or nodular in outline, extending from the hilum.

Enlarged lymph nodes, varying in number and density, imbedded in the thickened tissues of the hilum. One or both hila may be involved.

Diffuse shadows of varying density throughout the hilus. Occasionally there are cloudy masses with irregular outlines projecting into the adjacent tissue due to involvement of the deep parenchyma.

The Von Pirquet test is of greater value here than in any other type of tuberculosis, or at any other age. In fact, this test is of little value in later life. It will usually be found to be positive. In the diagnosis, as is easily seen, the toxic symptoms are of infinitely greater value. The history of exposure is of very great importance, remember history of exposure to servants may be of much more value than merely ascertaining if there were any family history of tuberculosis. Needless to say, all other sources of toxemia that could produce similar symptoms must be excluded before a positive diagnosis of hilum tuberculosis can be made.

Treatment: These children yield to Sanatorium treatment even more readily than do adults. Helio, and artificial heliotherapy, do wonders, if properly regulated. Tuberculin probably is of greater value in the glandular cases than in any other type.

Children today are the men and women of the future, the nation of tomorrow. What



kind of a nation will we be tomorrow if 66,000 of the children of Georgia today are potential tubercular adults of tomorrow? This estimate of 66,000 of tubercular taint and potentiality is modestly stated. Tomorrow's citizenry will be taxed for the care of these curable children today, but adult incurable tuberculates of that day.

What is Georgia doing to prevent these children from becoming actively tubercular, and if already actively tubercular, what to restore them to health? Very little. There is all too little being done for the mal-nourished child, very little to place the potentially tubercular child in open air schools. I know of but one open air school in Georgia, and that is municipal. Nothing is being done to hospitalize the already tubercular child. Why? Fundamentally, the reason is ignorance. Ignorance in the family and on the part of the State. Ignorance as manifested by not providing open air schools, preventoria, sanatoria, clinics and dispensaries. The State Sanatorium is not large enough and not well enough endowed by State funds to offer adequate number of beds for its adult applicants and no quarters nor equipment for properly caring for the State's tubercular children.

Something must be done quickly by the State, charitable organizations, churches, and individuals if we are to save the future men and women of the State of Georgia. Some day those few of us whose voices are crying out in the wilderness will be heard and listened to. Some day there will be a building equipped and dedicated to the care of these tubercular kiddies. Fifty-three need this treatment NOW, 66,000 need to be searched for tuberculosis. How long, oh, Lord; how long! Before Georgia's hoodwink will be removed and she will see the light. Gentlemen, yours is a vantage point and from your vantage point won't you add your voices to ours and help us show the State the terrible need?

Carry out this thought, this terrible thought, and let it ring over and over in your ears and then tell others that THERE ARE 66,000 UNDER PAR CHILDREN IN GEORGIA AND 53 AND MORE NEED

HOSPITALIZATION. MAYBE SOME OF THESE KIDS ARE YOURS!

"YOU HAVE HEARD THE SONG—HOW LONG, HOW LONG?"

### FRATERNALISM\*

H. J. Carswell, M. D.,  
Waycross, Ga.

Man is preeminently a social being. His social nature is the result of the interaction of all his separate and distinct natures. It consists in a balance of faculties. The industrial nature, the political nature, the intellectual nature, the religious nature, are only bricks and mortar out of which the social nature is constructed.

Man's industrial relation is his relation to the means of physical existence; his political relation is his relation to government and law; his intellectual relation is his relation to truth; his religious relation is his relation to his own actions; but his social or fraternal relation is his relation to his fellowmen. Hence the social relation is the highest one possible.

Manhood is the basic principle and love the binding force of fraternalism. Grounded on such lofty principles, what may we not reasonably expect from the spirit of fraternity? It embodies all that is best, all that is noblest, in the distinct natures of men.

The spirit of fraternalism is the common property of the world. It makes us more useful and more capable of enjoyment, no matter what sphere of life we occupy. Everywhere you turn the voice of cordial greeting sounds in your ear, and the warm hand of brotherly love is extended. Surely the potent power which has brought about this condition is one of Heaven's most priceless gifts to mankind.

The primary function of fraternalism is to bring together men with kindred interests, thoughts and ideals, so that they may enjoy each other's society and gain mutual benefit. They are banded together with the object that each individual may lend to the entire group the elements of strength and the talents which he possesses, and in turn

\*Read before the Eleventh District Medical Society at Valdosta, Ga., Jan. 13, 1925.



receive the help, inspiration and protection of the whole organization.

Fraternalism is to be valued for what is in it, and not for what may be gotten out of it. When two or more persons unite for purely material benefit, that union is not a fraternity but an association for purposes of business. But the vital and animating principle of true fraternalism is the element of brotherly love, sympathy and co-operation—the ability and willingness to sacrifice to the good of the whole some of the personal interest which may be at variance with the interest of the organization.

Fraternalism owes its enduring power to the fact that it develops friendship. With a friend, you do not have to be careful; he understands. He is like fire, that purifies all you do. He is like water, that cleanses all you say. He is like wine, that warms you to the bone. In true friendship, there must be both give and take. Patience and forbearance are its essential characteristics.

Again, the power of fraternalism lies in concerted action. Without unity and co-operation there can be no progress. In no previous period of the history of mankind has the power of united action meant so much as now. The tremendous expansion of industrial combination, the great aggregations of capital, the increasing tendency to form clubs, societies and organizations for specific ends, and, most insistent of all, the demand for a federation of nations; all these demonstrate the growing conviction that in concerted action alone lies the power of mankind to effect great and enduring results.

The spirit of fraternalism should so permeate every member of this society as to make the Eleventh District Medical Society second to none in the state. It should so permeate this Society that it would arouse the men in the smaller towns in our district to become members of their county societies, and then of the District Society. Every physician in our District should belong to this society, and the spirit of fraternalism and friendship such, that practically every member would be here today.

Our District Societies are destined to become our great medical units of the future. The membership of our County Societies, as

a rule, is so small that it is very difficult to create a spirit of fraternalism. While, at the same time, the State Association like the Southern and the American Medical Associations, is becoming too large to retain this spirit of social relationship or fraternalism. Hence the District Societies are destined to become the social or fraternal organizations of the Medical profession.

As we contemplate the principles which underlie true fraternalism and which govern its functions; as we devote our minds to a consideration of its beautiful teachings, their spirit and sentiment permeate our being, and we unconsciously learn to model our lives more and more in harmony with its truths.

#### **DILATION VERSUS GASTROSTOMY AS A PALLIATIVE TREATMENT OF CAR- CINOMA OF ESOPHAGUS**

In the Mayo Clinic, it has been the custom to dilate malignant strictures of the esophagus with graduated sounds, and P. P. Vinson and H. J. Moersch, Rochester, Minn. (Journal A. M. A., Feb. 28, 1925), are convinced that this can be done with greater safety, much less discomfort, and far greater relief than gastrostomy. The arguments that have been advanced against dilation are that it is dangerous, that it does not relieve dysphagia, and that it hastens metastasis. In 502 dilations for cancer of the esophagus at the clinic in the last six years, there have been three fatalities, due to splitting of the esophagus; and during the same period there have occurred three fatal spontaneous perforations in a group of seventy-five cases in which dilation was not performed. Fatal hemorrhage following instrumentation has never occurred, although hemorrhage is a frequent terminal event in esophageal cancer. The reason for the insignificant mortality following dilation is that a previously swallowed twisted silk thread is used as a guide in introducing sounds, and this effectually prevents perforation from puncture, the usual complication following the passage of an unguided dilator. The majority of patients with dysphagia are markedly relieved by dilation of the stricture with a 45 French olive, and deglutition remains fairly normal for from six to eight weeks. One patient had not had a return of dysphagia two and one-half years after a single dilation. The treatment does not require hospitalization, and the patient is permitted to return home the day after instrumentation. As the patient can then swallow without difficulty, there is no necessity for especially prepared foods, as is the case with tube feeding after a gastrostomy. Dilation should not be attempted in the presence of an esophagobronchial or an esophago-tracheal fistula; in such cases gastrostomy would be justifiable. Patients with malignant lesions of the upper esophagus, extensive metastasis to the cervical glands, and paralysis of one or both vocal cords, are not usually benefited by the passage of sounds, nor do they derive much comfort from gastrostomy. In cases of gastric cancer, if the lesion is located at the cardia and obstructs the lower esophageal opening, very little relief follows the passage of a sound, and in cases such as this a gastrostomy may lead to metastasis to the abdominal wall.

# THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Profession of Georgia.

65 Forrest Ave., Atlanta, Ga.

JUNE, 1925

ALLEN H. BUNCE, M. D., Editor  
 M. C. PRUITT, M. D., Business Manager  
 Publication Committee  
 CHAS. USHER, M. D.  
 S. J. LEWIS, M. D.  
 T. C. THOMPSON, M. D.

Articles are accepted for publication on condition that they are contributed solely to this Journal.

Manuscripts should be typewritten, double-spaced, and the original (not the carbon copy) submitted. Used manuscript is not returned unless requested.

Communications and items of general interest to the profession are invited from all parts of the State. We especially invite county society secretaries to send us information of happenings in the county that would be of interest to the members throughout the State.

## Editorial Department

### THE ANNUAL MEETING

The seventy-sixth annual meeting of the Medical Association of Georgia was held in Atlanta, May 13th, 14th and 15th, with headquarters at the Biltmore Hotel.

The fact that there were over six hundred members registered at this meeting is evidence of the increasing interest in the annual meetings throughout the State, this being the largest registration at any meeting in the history of the Association. In addition, there were over one hundred and fifty members of the Woman's Auxiliary present. Although the Auxiliary is only a year old, it is a healthy infant and we predict that it will pass through childhood, adolescence and reach maturity without any serious illness.

The Committee on Scientific work very wisely limited the papers to a number which could be completed during the time allotted. For the first time in our history only one essayist was absent, Dr. H. H. Martin, of Savannah, former President of the Association, who was in the hospital following an operation for acute appendicitis. Thus, we see, the increasing interest of those selected to appear on the program and also increas-

ing interest on the part of the members, since when a title appears they are sure the paper will be presented.

On Friday at twelve o'clock, as provided in the Constitution and By-Laws, the election of the new officers resulted as follows:

President, Frank K. Boland, Atlanta.

1st Vice-President, W. R. Daney, Savannah.

2nd Vice-President, H. M. Fullilove, Athens.

Secretary-Treasurer, Allen H. Bunce, Atlanta (5 years).

Parliamentarian, M. A. Clark, Macon (3 years).

Delegate to A. M. A., R. L. Miller, Waynesboro (2 years).

Alternate, C. W. Roberts, Atlanta (2 years).

#### COUNCILLORS

5th District, E. C. Thrash, Atlanta (3 years).

6th District, M. M. Head, Zebulon (3 years).

7th District, M. M. McCord, Rome (3 years).

8th District, Stewart D. Brown, Royston (3 years).

11th District, A. S. M. Coleman, Douglas (unexpired term, 1 year).

Our new President, Dr. Frank K. Boland, is one of the South's leading surgeons and has held many positions of trust in civil and medical circles. He is past President of the Fulton County Medical Society and was Chief of the Surgical Service, Base Hospital No. 43 (Emory Unit), A. E. F. He is at present, Professor of Surgery at Emory University School of Medicine and Lieutenant Colonel, M. R. C., U. S. A. Dr. Boland has pledged his best efforts in behalf of the Association and we earnestly request every member to assist him in every manner possible during his tenure of office.

#### DOES HEALTH EDUCATION PAY?

Success in life and achievement in any vocation depends upon mental alertness. To begin the race of life with mental or physical handicap, places a serious barrier in the pathway. Even physical prowess must be



directed by a keen and discriminating mentality. Thus the athlete, whether on the gridiron, the diamond, in the squared ring or on the track, fails to win in the highest measure, unless his trained muscles are directed by a mentality which takes advantage of all the breaks in the game.

It can therefore be established beyond the possibility of successful contradiction that healthy people, the triad man—health of mind, of body and of soul—is more efficient in all life's endeavors than is the cripple, whether defect resides in one or all of the aforesaid attributes.

If it is accepted that the world's progress has depended upon the transmission of information from one race to another—if progress follows where people are capable of being taught—it must be apparent that healthy people are more teachable than those hampered by mental or physical defect or those torn by strife and distrust in personality.

The criminal annals of the world are filled with statistics which clearly suggest that violators of the law are almost entirely sufferers from disease of some nature. It has always been hard for sick people to be good. Sickness breeds distrust, suspicion and a willingness to violate the law. Unhealthy people are less law-abiding.

It must follow, therefore, that the economic development of a people is largely dependent upon physical, spiritual and mental manhood. Poverty paralyzes the wheels of industry and physical poverty is the great epidemic which feeds into the commonwealth a high per cent of its indolent citizens. Poverty is to be resented with a holy disgust. It strips the individual of incentive and lays heavy burdens on his progress. Good health is the most effective weapon against this monster destroyer of the hopes and ambitions of people everywhere.

Unhealthy people are hard to teach. Moreover, they stand in the way of those who, possessing strong minds and bodies, march in the van of progress. Large sums of public school funds are lost by attempts to teach the irresponsive child. Public monies are thus wasted. The remedy is the giving of thought to corrective measures which, when

applied, makes it possible to develop an individual who otherwise struggles against insurmountable difficulty.

Courts, houses of correction, juvenile homes for incorrigibles, large police forces would find far less work to do if our population was healthy. Such institutions, made necessary by violation of law, cause a heavy drain on public funds and thus divert from constructive purposes monies which might be used for more effective service to the people. The remedy again is giving thought, first, to the health development of our children as well as the adult population. First the physical machine and then the super structure. A house, if built upon the sand, will not stand.

Health education does pay. Sick people are less efficient, are less teachable, are less law-abiding. Health education improves the economic welfare of a nation, state or city, maintains a constant barrage against poverty, saves the people's taxes by eliminating wasted investment in efforts to teach the sick and underprivileged in the same school with the physically fit as well as offering a method of reclaiming enormous court costs made necessary in the effort to control the menace against society brought about largely by the conduct of the irresponsible group, a class fettered by physical handicap and thus made vulnerable to the onslaught of vice.

Is it not time to recognize that we are living in a new world? Progress is dependent upon building on a healthy foundation. Thoughtful students of the welfare of humanity are ready to agree with public health workers that many of the ills to which humanity is subjected can be corrected.

It is the duty of all forward-looking citizens to give sympathetic hearing and active co-operation in their effort to discover and correct physical conditions which have for so long impeded progress but should now be outlawed. People are not necessarily the victims of disease. The Science of Public Health and Preventive Medicine has clearly marked the pathway. If we will but walk therein our rewards will quickly become manifest. Ignore the truths of Preventive Medicine and as race or individual we fall.

C. W. Roberts.



## District and County Societies

The Secretary of each county society shall report to the Journal of the Medical Association of Georgia full minutes of each meeting and forward to it all scientific

papers and discussions which the society shall consider worthy of publication.—Constitution and By-Laws, Chap. VII, Sec. 15.

1. Demmond, E. Carson, Savannah.
2. Wood, A. W., Albany.
3. Greer, Chas. A., Oglethorpe.
4. Blackmar, Francis B., Columbus.
5. Clay, Grady E., Atlanta.
6. Hawkins, T. I., Griffin.

7. McCord, M. M., Rome.
8. Carter, D. M., Madison.
9. Bennett, J. C., Jefferson.
10. Lee, F. Lansing, Augusta.
11. Penland, J. E., Waycross.
12. Cheek, O. H., Dublin.

### HONOR ROLL

The following is a list of 100 per cent counties for 1925. The date on which each became a 100 per cent society appears after the name of the society, together with the name of the Secretary:

1. Randolph County, Dr. G. Y. Moore, Cuthbert, December 9, 1924.
2. Dougherty County, Dr. J. A. Redfearn, Albany, December 10, 1924.
3. Pike County, Dr. M. M. Head, Zebulon, December 12, 1924.
4. Hart County, Dr. W. E. McCurry, Hartwell, January 3, 1925.
5. Warren County, Dr. A. W. Davis, Warrenton, January 14, 1925.
6. Monroe County, Dr. W. J. Smith, Juliette, January 14, 1925.
7. Lamar County, Dr. John M. Anderson, Barnesville, March 6, 1925.
8. Upson County, Dr. B. C. Adams, Thomaston, March 30, 1925.
9. Emanuel County, Dr. S. S. Youmans, Oak Park, May 5, 1925.
10. Stephens County, Dr. C. L. Ayers, Toccoa, May 11, 1925.
11. Turner County, Dr. J. H. Baxter, Ashburn, May 12, 1925.
12. Evans County, Dr. D. S. Clanton, Hagan, May 14, 1925.

### FIRST DISTRICT MEDICAL SOCIETY

An interesting meeting of the First District Medical Society was held April 8, 1925, in the Court House at Sylvania. It was called to order at 10:30 o'clock by Dr. W. R. Lovett, Sylvania, in the absence of the President, Dr. B. B. Jones, Metter. Dr. E. M. Gleaton, of Savannah, acted as Secretary, in the place of Dr. E. C. Demmond, who was unable to attend.

The following scientific program was carried out:

"Two Cases of Uterine Fibroids, With Remarks as to the Cause of These Tumors," Dr. Cleveland Thompson, Millen.

"Hematuria," Dr. William Shearhouse, Savannah.

"A Few Diagnostic Points, Yet Unpublished, in Incipient Tuberculosis," Dr. L. F. Lanier, Rocky Ford.

"Cysts of the Mesentery," Dr. Chas. Usher, Savannah.

"Complemental Versus Supplemental Infant Feeding," Dr. R. L. Miller, Waynesboro.

"Acidosis," Dr. E. N. Gleaton, Savannah.

"Colitis," Dr. P. H. Smith, Glennville.

"Gall Bladder Drainage," Dr. W. R. Dancy, Savannah.

"The Interpretation of Blood Pressure Readings," Dr. J. W. Daniel, Savannah.

"Fractures of the Ankle," Dr. G. R. White, Savannah.

"Good Vision as a Business Asset," Dr. E. S. Osborne, Savannah.

About forty doctors were present.

### SECOND DISTRICT MEDICAL SOCIETY

I am glad to report another excellent meeting of the Second District Medical Society, which was held at Bainbridge, March 13th. So excellent are the programs, and so sumptuous and hearty the entertainment by the hosts, that these meetings are looked forward to by the progressive men of this District with much pleasure and profit.

Dr. Gordon Chason, Bainbridge, presiding, the meeting was called to order, and after invocation by Rev. Mr. Shell, and a few well-chosen words of welcome by Mr. Nussbaum, one of the leading citizens, the minutes of the last meeting read, and the program of papers begun.

First on the program was Dr. W. L. Wilkinson, of Bainbridge, on "My Observations in the Use of Acriflavine," which he discussed in connection with such cases as pneumonia, septicemia, chronic cystitis, appendicitis (fulminating), peritonitis, etc., advocating its use particularly in intra-abdominal infections where the colon bacillus is the principal organism. He reported several cases coming under his care.

Discussing the subject, Dr. C. K. Wall, Thomasville, advocated the use of mercurochrome in cases of this kind, reporting several cases.

Dr. A. D. Little, Thomasville, stated that he has noted a lack of reaction in the use of areiflavine, compared to mercurochrome. He feels that there is a great field of usefulness for this drug.

Dr. Davis, of Quincy, Fla., has been using aeriflavine for some five years, and advocates the use of smaller doses and quantities of solution. Cases of Neiser, colon bacillus, and staphylococcus are benefited, but not the streptococcus haem. He reported one case, to illustrate.

Dr. Gordon Chason, Bainbridge, advocates the use of neutral ampoules of the solution, particularly in such cases as reported by Drs. Wilkinson and Davis, and notes the comparative lack of reaction.

Dr. Chas. H. Watt, Thomasville, states that the best effects are in blood infections (to be determined by blood culture) and has but little effect in cases that have not become blood-laden.

Dr. C. K. Sharp, Arlington, urges the use of freshly distilled water, in preparing solutions.

Dr. Wilkinson, in closing, urges normal saline instead of distilled water as diluent of acriflavine. He expects to continue its use, and later, to extend its use to other than desperate cases.

Dr. J. W. Daniel, Savannah, past President of the Medical Association of Georgia, honored us with his presence, and a most helpful discussion of "Nephritis, with Report of Cases." He presented two types of acute nephritis: Those with coma and those of convulsions. Those with coma have the hy-

drogen or acid ion, associated with high blood sugar, low phenolphthalein output, non-protein nitrogen retention, and acidosis. In nephritis there is amino acid, as due to faulty metabolism. The convulsive cases are due to alkalosis, as in tetany, rather than acidosis. There is a high chloride balance. In oedema there is acidosis. Calcium chloride liberates sodium, thereby eliminating chlorides and oedema.

In surgery, post operative vomiting, there may be alkalosis from X-Ray, intestinal obstruction, and the administration of alkalis internally. In vomiting of intestinal obstruction, there is a low chloride balance, due to toxic conditions utilizing the chloride reserve.

Nephritis is due to infection—either in the kidney or other foci. Drugs are of no value except in those cases due to cardiac stasis. The acidosis may be overcome by basic diet, or the use of alkalis.

Dr. Watt asked as to the method of handling such cases as low chloride in obstruction and Dr. Warnell, as to diet, in these cases.

Dr. Daniel, closing, replied to Dr. Watt's inquiry, by urging an early diagnosis in cases of vomiting in surgical conditions, to be determined by clinical symptoms and the blood analysis for basal metabolism.

To Dr. Warnell, he stated that in the oedematous or acidosis cases, a basic diet should be given, such as milk, fruits, vegetables, and sugar. Contraindicated in these cases are breads, cereals (grits, rice, etc.), and meats.

Next on the program was Dr. A. D. Little, of Thomasville, on "Surgery of the Outside of the Chest." First he dealt with surgery of the breasts, mastitis and neoplasm being the two conditions discussed. In mastitis, the infection is due to carelessness in handling the nipples during the nursing period. He urges early attention to pus formation, with early and thorough evacuation.

In neoplasm, there is the benign and malignant. Early differential diagnosis is important, and surgical treatment should be instituted early—local if benign, radical if malignant. Avoid manipulation and pressure in examination. He urges radium before and after operation.

Thorocotomy in empyema should be done by resecting enough rib to allow free drainage. He also calls attention to thorocotomy as a means of checking hemorrhage.

Dr. Watt, in discussing the subject, calls attention to the possibility of leaving pockets unless intra-abscess adhesions are broken up by running the finger over the abscess area.

Dr. Gordon Chason at this point states that too much reaction may be produced by breaking up adhesions or too much manipulation, especially in streptococcus hemolyticus infection.

Dr. Little, closing, urges surgical judgment in these cases as in other cases of surgery.

"Focal Infection, with Some Detailed Observations," by Dr. J. F. Covington, Moultrie, and Dr. J. A. Summerlin, of Hartsfield, was begun by Dr. Covington, by calling attention to borderline or obscure abscess conditions existing in many places, as teeth, tonsils, adenoids, ethmoid, mastoid, antrum or sinus infections, prostate, endocervicitis, salpingitis, appendicitis, cholecystitis, etc. He pointed out that asthenia may be traced to focal infection, as may be empyema, endocarditis, etc. He urges the care of early teeth. He also pointed out that acute nephritis may be traced to foci of infection, especially in children.

Dr. Summerlin advocates the use of mercurochrome in the treatment of focal infection, especially in those remote cases where surgical eradication cannot be readily resorted to.

Dr. J. W. Daniel, discussing the paper of Drs. Covington and Summerlin, stated that focal infection is basis of metabolic disturbance, and frequently begin early in life, and may be permanent. They may not be cured, but arrested by removal of the infection.

Dr. Covington, closing, cites cases illustrating the use of mercurochrome in these cases.

At this time Dr. M. A. Fort, local County Health Commissioner, made a report of his work in Decatur, Seminole and Miller Counties, in the eradication of malaria and hookworm diseases as well as other devitalizing conditions as tonsils, teeth, etc. He urged better support of Public Health work in Georgia.

Mr. Jas. L. Bevans, Director of the Archbold Hospital at Thomasville, as guest of the Thomas County Delegation, outlined the work of the hospital and its plans for the care of nurses, patients and doctors, inviting the doctors to inspect the plant when in Thomasville.

After a delightful luncheon served by the civic clubs of Bainbridge and the local Medical Society at the Bainbridge Country Club, the session was resumed, and report of the committee to nominate officers for the coming year and to arrange the program and place of meeting in September was submitted, as follows:

President, Dr. C. K. Sharp, Arlington.

Vice-President, Dr. J. A. Summerlin, Hartsfield.

Secretary-Treasurer, Dr. A. W. Wood, Albany.

Those requested by the committee to read papers at the next meeting were:

Dr. H. M. Moore, Thomasville, "Headache From Eye Strain, and Treatment."

Dr. J. C. Keaton, Albany, some paper on surgery, with Dr. C. K. Wall, Thomasville, associate.

Dr. L. A. Baker, Tifton, on Pediatrics, with Dr. J. A. Redfearn, Albany, as associate.

Dr. J. A. Summerlin, Hartsfield, on medicine, and Dr. J. B. Warnell, Cairo, as associate.

Cairo was selected as the next meeting place, September 9.

After some discussion of the matter of membership in the District Society, a motion by Dr. A. D. Little, that the Secretary of the County Societies make report to the Secretary of the District Society of those who wished to have membership in the District Society, together with a fee of \$1.00 per member, which shall be the fee hereafter, instead of \$2.00, was carried.

By way of personal comment, our meetings are becoming more and more interesting and profitable. We have good papers and good discussions, as well as good attendance and good fellowship. We greatly enjoyed Dr. Daniel and his discussions.

Yours very truly,

A. W. WOOD, Secretary



### FLOYD COUNTY MEDICAL SOCIETY

Dr. and Mrs. Harry Mull entertained the members of the Floyd County Medical Society, of which Dr. Mull is Secretary-Treasurer, at their home in Rome, April 24, 1925, at the regular monthly meeting of the Society. At 6:30 p. m., a delicious buffet dinner was served.

Papers were read by Dr. Arthur C. Shamblin, "Certain Pelvic Abnormalities," and Dr. John L. Garrard, "The Value of Cystoscopy in Making a Diagnosis."

A rising vote of thanks was extended to Dr. and Mrs. Mull at the end of this enjoyable meeting.

Those present were: Drs. R. O. Simmons, Rome, President; A. F. Routledge, Rome, Vice-President; R. M. Harbin, Rome; J. T. McCall, Rome; M. M. McCord, Councillor, Seventh District; W. J. Shaw, Rome; G. B. Smith, Rome; J. L. Chandler, Rome; A. H. Dellinger, Rome; Clifford Moore, Lindale, Delegate; J. P. Ballenger, Armuchee; R. C. Maddox, Rome; J. C. Watts, Rome; J. L. Garrard, Rome, Alternate; A. C. Shamblin, Rome; R. P. Cox, Rome; C. H. McArthur, Armuchee; H. A. Turner, Rome; R. H. Wicker, Rome; B. V. Elmore, Rome, and Harry Mull, Secretary-Treasurer.

### REPORT OF TELFAIR AND RANDOLPH COUNTIES

Before the 1925 annual meeting was held, letters were received from Dr. C. J. Maloy, Helena, Secretary, Telfair County Medical Society, and Dr. G. Y. Moore, Cuthbert, Secretary, Randolph County Medical Society, stating that they would be unable to attend the Secretaries' Conference, which was held during the meeting, and enclosed their reports.

Dr. Maloy was unable to attend on account of leaving a few days before to take a six weeks' course at the New York Post-Graduate Medical School, New York. In Dr. Maloy's report, he stated that "Our membership has increased 2. No deaths. 'Doing a good work.'"

Dr. Moore informed us that it was impossible for him to attend, and that he had asked

Drs. J. C. Patterson, Cuthbert, and F. M. Martin, Shellman, to meet with the Secretaries, if possible. Dr. Moore's report for the past year was "Our Society has not missed a meeting during the past year. We have a program for each meeting and every member, when called upon, will read a paper, with all members present taking part in the discussions. Our average attendance has been more than 90 per cent. Our Society is on the Honor Roll as being 100 per cent in membership."

### COUNTY SOCIETIES REPORTING FOR 1925 TERRELL COUNTY MEDICAL SOCIETY

The Terrell County Medical Society announces the following officers for 1925:

President, Dr. J. T. Arnold, Parrott.

Vice-President, Dr. R. R. Holt, Parrott.

Secretary-Treasurer, Dr. Logan Thomas, Dawson.

Delegate, Dr. Steve P. Kenyon, Dawson.

Alternate, Dr. J. C. Dean, Dawson.

Board of Censors, Dr. Lucius Lamar, Dawson.

### WAYNE COUNTY MEDICAL SOCIETY

The Wayne County Medical Society announces the following officers for 1925:

President, Dr. A. J. Gordon, Jesup.

Vice-President, Dr. T. C. Ritch, Jesup.

Secretary-Treasurer, Dr. J. T. Colvin, Jesup.

Delegate, Dr. A. J. Gordon, Jesup.

### HABERSHAM COUNTY MEDICAL SOCIETY

The Habersham County Medical Society announces the following officers for 1925:

President, Dr. W. V. Chandler, Baldwin.

Vice-President, Dr. P. Y. Duckett, Cornelia.

Secretary-Treasurer, Dr. R. B. Lamb, Demorest.

Delegate, Dr. O. N. Hardin, Cornelia.

Alternate, Dr. P. Y. Duckett, Cornelia.

### GLYNN COUNTY MEDICAL SOCIETY

The Glynn County Medical Society announces the following officers for 1925:

President, Dr. J. A. Dunwoody, Brunswick.

Vice-President, Dr. R. E. L. Burford, Brunswick.

Secretary-Treasurer, Dr. J. P. Harrell, Brunswick.

Delegate, Dr. J. W. Simmons, Brunswick.

Alternate, Dr. C. B. Greer, Brunswick.

Board of Censors, Drs. J. W. Simmons, H. M. Branham and C. B. Greer, all of Brunswick.

### **STEPHENS COUNTY MEDICAL SOCIETY**

Stephens County is among the four new Societies reporting 100 per cent since the May issue went to press. It announces the following officers for 1925:

President—Dr. W. M. Fresh, Toccoa.

Vice-President, Dr. E. F. Chaffin, Toccoa.

Secretary-Treasurer, C. L. Ayers, Toccoa.

Delegate, Dr. C. L. Ayers, Toccoa.

Alternate, Dr. J. H. Terrell, Toccoa.

Board of Censors, Drs. J. E. D. Isbell, E. F. Chaffin and J. H. Terrell, all of Toccoa.

### **RICHMOND COUNTY MEDICAL SOCIETY**

The Richmond County Medical Society announces the following officers for 1925:

President, Dr. W. J. Cranston, Augusta.

Vice-President, Dr. C. I. Bryans, Augusta.

Secretary-Treasurer, Dr. M. P. Agee, Augusta.

Delegates, Dr. W. A. Mulherin, Augusta, Dr. A. A. Davidson, Augusta.

Alternates, Dr. Jos. Akerman, Augusta, Dr. V. P. Sydenstriker, Augusta.

### **JACKSON COUNTY MEDICAL SOCIETY**

The Jackson County Medical Society announces the following officers for 1925:

President, Dr. O. E. Shankle, Commerce.

Vice-President, Dr. W. C. Kennedy, Talmo.

Secretary-Treasurer, Dr. J. C. Bennett, Jefferson.

Delegate, Dr. R. Freeman, Hosehton.

Alternate, Dr. H. E. Crow, Talmo.

Board of Censors, Drs. F. M. Hubbard, Commerce; S. J. Smith, Jefferson, and J. B. Pendergrass, Jefferson.

### **BLUE RIDGE COUNTY MEDICAL SOCIETY**

The Blue Ridge Medical Society announces the following officers for 1925:

President, Dr. J. M. Daves, Blue Ridge.

Vice-President, Dr. N. C. Coss, Ellijay.

Secretary-Treasurer, Dr. C. B. Crawford, Blue Ridge.

Delegate, Dr. C. B. Crawford, Blue Ridge.

Alternate, Dr. J. S. Tankersley.

Board of Censors, Drs. C. J. Welborn, Blairsville; N. C. Goss, Ellijay, and J. S. Tankersley, Ellijay.

### **McDUFFIE COUNTY MEDICAL SOCIETY**

The McDuffie County Medical Society announces the following officers for 1925:

President, Dr. S. Gibson, Thomson.

Vice-President, Dr. W. A. Gibson, Thomson.

Secretary-Treasurer, Dr. F. G. Colvin, Thomson.

### **EVANS COUNTY MEDICAL SOCIETY** (100%)

Evans County, formerly a part of the Tattall-Evans Counties Medical Society, was recently issued a charter, and on the 14th of May a check was received from Dr. Clanton, Secretary, covering State dues for every member in his county, making it a 100 per cent Society. The officers for 1925 are:

President, Dr. B. E. Miller, Claxton.

Secretary-Treasurer, Dr. D. S. Clanton, Hagan.

### **PUTNAM COUNTY MEDICAL SOCIETY**

The Putnam County Medical Society announces the following officers for 1925:

President, Dr. V. H. Taliaferro, Eatonton.

Vice-President, Dr. E. F. Griffith, Eatonton.

Secretary-Treasurer, Dr. S. A. Clark, Eatonton.

Delegate, Dr. V. H. Taliaferro, Eatonton.

Board of Censors, Drs. V. H. Taliaferro, E. T. Griffith, of Eatonton, and Dr. E. T. Walker, Willard.

### **MURRAY COUNTY MEDICAL SOCIETY**

We were glad to get a report from Dr. J. E. Bradford, Secretary, in which he stated that Murray County had reorganized with five members. They were immediately issued a charter, and the following officers elected for 1925:

President, Dr. R. H. Bradley, Chatsworth.

Vice-President, Dr. T. W. Colvard, Crandall.

Secretary-Treasurer, Dr. J. E. Bradford, Spring Place.

### NEWS ITEMS

The numerous friends of Dr. J. L. Lovvorn will be interested to learn that he is recovering from a serious illness at his home in Carrollton. Dr. Lovvorn is a member of the Carroll County Medical Society.

Dr. Clifton G. Kemper has recently returned from New York where he had an appointment at Lying-in Hospital. He is now associated with Drs. L. P. Daly and G. F. Spearman, 41 Forrest Avenue, Atlanta.

Dr. John S. Derr announces the installation of a high voltage equipment for deep x-ray therapy in his offices, Suite 008 Hurt Building, Atlanta.

Dr. C. J. Maloy, Secretary of the Telfair County Medical Society for the past several years, has returned to his home in Helena after taking a six weeks' post-graduate course at the New York Post-Graduate Medical School.

Dr. T. J. Busey has removed from Tyrone to Fayetteville. He is President of the Campbell County Medical Society.

Dr. Everett L. Bishop, formerly a resident of Savannah and a member of the Chatham County Medical Society, is being welcomed in Atlanta where he has accepted the appointment as Pathologist to the Albert Steiner Cancer Clinic, Grady Hospital, Atlanta.

The friends of Dr. B. M. Johnson regret to learn that he has moved from Macon to Columbus, Mississippi, where he is affiliated with the Columbus Hospital.

Dr. H. D. Coffee is now connected with the Veterans Bureau at Milwaukee, Wisconsin. He was formerly of Athens and is a member of the Bibb County Medical Society.

Dr. R. M. Harbin, Rome, was the invited guest at the April meeting of the Medical and Surgical Staff of the Georgia Baptist Hospital. His paper was on "Making a Diagnosis". Dr. Hal Davison, Atlanta, read a paper on "Indigestion".

Dr. Kimsy E. Foster, College Park and a member of the Fulton County Medical Society, has recently returned from a three weeks' motor trip through Georgia and Florida.

Dr. Guy Lunsford was host to the members of the Stewart-Webster Medical Society at his home in Weston, Wednesday night, April 22, 1925. Mrs. Lunsford assisted him in entertaining.

Dr. W. G. Post, formerly of Macon, now has offices in the First National Bank Building, St. Petersburg, Florida. His friends are wishing him continued success in his new location.

Mr. Jacob Elsas, President of the Fulton Bag and Cotton Mills, Atlanta, has donated \$100,000 for the construction of a pay ward at Grady Hospital, Atlanta. The only condition attached to this gift is that the City raise \$300,000 for the same purpose within three years.

Dr. William C. Warren announces that his son, Dr. William C. Warren, Jr., is now associated with him. They have offices in the Atlanta National Bank Building, Atlanta, and limit their practice to Diseases of the Ear, Nose and Throat.

Dr. W. L. Funkhouser, President of the Pediatric Section of the Fulton County Medical Society, Atlanta, addressed the mothers of Atlanta on "Healthful Diet for Children" during the Child Health Week.

Dr. O. B. Walker, Bowman, and a member of the Elbert County Society, was elected 1st Vice-President of the Georgia Eclectic Association, at its meeting April 16, 1925. Dr. S. R. Harbin, of Canton and Vice-President of the Cherokee County Society, served as 2nd Vice-President during 1924; Dr. John Powell served as Secretary. Dr. Powell is from Atlanta and is a member of the Fulton County Society.

Dr. Max Thorek, connected with the American Hospital of Chicago, has been made a member of the Surgical Society of Paris, France, and also a Corresponding member of the Royal Academy of Medicine and Surgery, of Torino, Italy. Dr. Thorek is one of our former advertisers.

The \$275,000 hospital at Fort Benning, Columbus, is now open. It is modern in every respect, has complete operating rooms for all character of patients, houses its entire medical department, including medical, surgical, dental, x-ray, eye, ear, nose and throat clinics. The hospital has a capacity of 102 beds.



The members of the Crisp County Medical Society held an all-day clinic at the Court House in Cordele, April 24, 1925. It was conducted by the faculty of the University of Georgia Medical School at Augusta. The Crisp County doctors invited the physicians of Doofy, Wilcox and Turner Counties as their guests. The visiting physicians furnished cases for the clinic and were later entertained at a dinner that night.

Dr. J. M. Poer, West Point, was elected President of the Railway Surgeons of Georgia at its annual meeting held at the Biltmore, Atlanta, May 12, 1925. Dr. Poer succeeds Dr. Cleveland Thompson, Millen. Dr. H. M. Fullilove, Athens, was elected 1st Vice-President; Dr. J. P. Bowdoin, Atlanta, 2nd Vice-President; Dr. W. M. Folks, Waycross, 3rd Vice-President, and Dr. J. W. Palmer, Ailey, re-elected Secretary-Treasurer. Dr. A. S. M. Coleman, Douglas, was added to the Executive Committee.

Dr. A. C. Shamblin, Rome, was re-elected on the Board of Directors of the Floyd County Public Health Association for 1925-1926.

The McDuffie County Medical Society held its annual meeting during April in Thomson. Those present were: Drs. S. Gibson, President; W. A. Gibson, Vice-President; F. G. Colvin, Secretary-Treasurer; S. A. Boland and L. L. Dozier, all of Thomson. McDuffie County Society has increased its membership from four during 1924 to seven for 1925.

The Clarke County Medical Society is conducting clinics, with the assistance of the Committee of Medical Extension of the Department of Medicine of the University of Georgia at Augusta. Dr. V. P. Sydenstricker, of the Department of Medicine; Dr. W. A. Mulherin, Professor of Pediatrics, and Dr. H. B. Neagle, Professor of Preventive Medicine, represented the Committee in Athens.

At a meeting of the Ware County Medical Society held May 6, 1925, it was decided that all doctors offices would be closed during the summer months on Thursday afternoons, of course, continuing to answer all emergency telephone calls.

A total of 5,020 patients were treated at the University Hospital, Augusta, during 1924, which is an increase of 311 over last year and 988 over the year 1922. It is interesting to note that there

was very little difference in cost on account of the increase in number of patients. These facts were included in the report of Dr. Carlisle S. Lentz, Superintendent of the Hospital.

Dr. H. G. Weaver, Macon, has been elected Secretary-Treasurer of the Bibb County Medical Society for the remainder of the year 1925. This vacancy was caused by the removal of Dr. R. S. Muckenfuss, formerly of Macon.

The Homan Sanatorium, El Paso, Texas, which is devoted to the treatment of tuberculosis, has moved into a new and much larger building. Dr. R. B. Homan, Medical Director, informs us that as their new sanatorium building is modern and complete in every respect, they are in a position to give the very best of accommodations to any class of patients.

The National Tuberculosis Association held its 21st annual meeting in Minneapolis, Minnesota, June 17-20, 1925.

## COMMUNICATIONS

To the Secretary:

It has been suggested to us that your organization will probably wish to place upon its annual meeting agenda announcement of the compilation of the 1st or 1925 edition of WHO'S WHO IN AMERICAN MEDICINE.

Many of your members will have received questionnaires relating to this, and in the interest of a work as valuable and as comprehensive as possible, we wish to urge upon them the importance of promptly supplying the requested data.

At this time we would make announcement of the merging of our contemplated 1st edition of WHO'S WHO OF AMERICAN PHYSICIANS & SURGEONS with the 1st edition of WHO'S WHO IN AMERICAN MEDICINE developed by the National Park Publishing Co., of Hot Springs National Park, Arkansas.

Dr. Loyd Thompson and Mr. Winfield Scott Downs will act as co-editors of this more comprehensive contribution to biographical literature.

Any further information you need may be obtained from the writer. Thanking you for whatever assistance you may render in making this a complete edition, we are,

Yours very truly,

WHO'S WHO PUBLICATIONS, Inc.

M. M. Lewis, Secretary.

**CANCER COMMISSION**  
**Of The**  
**MEDICAL ASSOCIATION OF GEORGIA**  
**Office of the Chairman**

Atlanta, Ga., March 25, 1925.

My Dear Doctor:

I am taking the liberty to call your attention to a few more facts about cancer.

I

About 5 per cent of all cancers are located in the buccal cavity and on the lips. The majority of these lesions are in men past fifty years of age. They are caused by the excessive use of tobacco, oral sepsis and bad teeth. They are largely of the squamous cell type and respond badly to treatment; now and then an early one may be cured.

Prevention, therefore, is the best way to save the lives of the one hundred and fifty individuals who will have cancer of the mouth in Georgia within the next year.

II

About 45 per cent of all cancers are found in the alimentary canal and accessory organs of digestion. They occur with about equal frequency in both sexes, between the ages of thirty-five and sixty, though cancer of the rectum is occasionally seen at a much earlier age.

Statistics from some of the large clinics show that cancer of the stomach is often preceded by "ulcer symptoms" for many years, and gall-stones not infrequently cause malignant degeneration in the wall of the gall-bladder.

An early diagnosis is difficult, but certain forms of indigestion should lead us to pursue our investigations further and use every means at our command.

Cancer of the small intestine is so rare as to merit no consideration in a communication of this nature; but in the large intestine they are quite frequent, increasing in number from the secum to the anus. The most common early symptom is a rumbling of gas accompanied by obstinate constipation and pain of moderate severity.

It is believed that cancer is more often seen in the large intestine because of its acid contents, acute angulation at certain points, and its fixed position in the abdominal cavity.

If an early diagnosis can be made, surgery offers some hope of a permanent cure because of the scanty lymphatic supply in certain portions of the gut.

Prolonged dysentery in an individual past fifty years of age should never be neglected; a careful investigation will frequently disclose cancer of the rectum or lower sigmoid.

III

"You know it is a serious thing to be a woman," because the female reproductive organs are so liable to cancer; fully 30 per cent of all cancers are found in the mammary glands and uterus of women over thirty-five years of age. For this reason three times as many women as men die of cancer between the ages of thirty-five and forty-five, and twice as many between forty-five and fifty-five.

A painless lump in the breast of a woman thirty-five years of age and over should never be dismissed with a casual examination, or with the remark, "let it alone if it doesn't trouble you, don't trouble it." Impress on every woman who has a lump in her breast the following facts: "If it becomes adherent to the skin; if it remains long enough for the glands in the axilla to be felt, or a lump appears in the other breast, there is little hope of a permanent cure." If the lump is painful during menstruation, is freely movable, and has not existed too long, a simple procedure will often effect a permanent cure, but at the time of removal it should be examined by a competent pathologist before giving a definite prognosis.

When a woman over thirty-five who has borne one or more children complains of a "watery discharge" between her periods, excessive flow, loss of strength, etc., make a careful examination; it can do no harm and may save a valuable life.

IV

Cancers of the skin are very numerous. Those on the face are usually seen in elderly people and respond readily to radium and X-Ray. In other parts of the body they are, as a rule, developed from the squamous cells and do not yield so readily because metastasis takes place early, but if seen early enough they can be cured by radium.

The flat bluish black mole is a serious lesion because from it develops a melanotic cancer of the most malignant type. Very careful treatment is required or more harm than good will be done.

### V

Fully 15 per cent of all cancer deaths reported to our Bureau of Vital Statistics are unclassified. We know, however, that there are many sarcomas in young people. The long bones are favorite locations; the kidneys and other glands are sometimes involved. Many of these lesions are easily controlled by radiation while others are unaffected.

Your cancer commission hopes that you will use every opportunity afforded you to call attention to the simple facts in connection with the early recognition of cancer and urge the doctors of your community to insist on early and radical treatment of all suspicious lesions.

If you have not already sent us the questionnaire, please do so at once, and oblige. I want it in time to compile the facts for the meeting of the State Association here in May.

Assuring you of our best wishes and kindest regards, we are,

Yours fraternally,

CANCER COM. MED. ASSO. OF GA.

J. L. Campbell, Chairman.

### SIMPLE IMMEDIATE TREATMENT FOR VOMITING

All patients suffering from symptoms of reverse peristalsis in the upper gastro-intestinal tract from various causes, were given amounts of 2 per cent. sodium chlorid solution varying from 50 to 200 c. c. In every case there was immediate relief of symptoms, but in several cases the relief was transient. Edwin P. Lehman and Harry V. Gibson, St. Louis (Journal A. M. A., April 25, 1925), suggest the possibility that the action is a local one, tending to establish forward peristalsis in the stomach, no matter what the cause of the reversal. It may be found that the expression of this effect in amelioration of symptoms depends on the intensity of the abnormal stimuli to, reversal of peristalsis. The treatment is so simple and harmless that it deserves a trial by clinicians everywhere, with a view to confirming or disproving these observations.

### THE NEW SCARLET FEVER STREPTOCOCCUS ANTITOXIN LILLY

Dear Doctor:

Scarlet fever Streptococcus Antitoxin, Lilly has been made available through license by the United States Treasury Department for interstate sale.

This product, prepared by the Dochez method, is to be used for the prophylaxis and treatment of scarlet fever along the lines so successfully carried out with diphtheria antitoxin. Scarlet fever Streptococcus Antitoxin, Lilly is the first of the newer scarlet fever measures, concerning which there has been so much publicity during the past year, to be released for sale. It should not be confused with the anti-scarlatinal serums which have been marketed for some years.

The researches which have been conducted in our laboratories on the preparation of a potent scarlet fever therapeutic serum have shown quite conclusively that of the two methods of production proposed, that of the Drs. Dick of Chicago and that of Dr. A. R. Dochez of the Presbyterian Hospital, New York, the latter produces an end product which has a higher concentration of antitoxin and contains in addition valuable bactericidal substances. The chief difference in the two methods is, that the Dicps immunize the horse against the soluble toxin or poison of the specific scarlet fever streptococci only, whereas Dochez immunizes the animal against not only the toxin of the organism but against the whole organism as well. Since scarlet fever is a combination of toxic effect and bacterial infection, the advantages of the Dochez method are apparent.

In all of our work, both laboratory and clinical, we have been permitted very close association with Dr. Dochez during the past year. Therapeutic trial of the serum indicates that it is of unquestionable value in the treatment of severe cases of scarlet fever. Intramuscular injection of the serum in therapeutic doses early in the course of the disease results in a rapid clinical cure as evidenced by a critical fall in temperature and pulse to normal, rapid fading of the rash and a prompt return to a state of well-being.

A word with regard to the toxin for active immunization is in order at this time. Our studies on the establishment and duration of immunity following injections of gradually increasing doses of scarlet fever streptococcus toxin have shown that while active immunization is rather quickly induced, that is, within three weeks after beginning treatment, it is lost very rapidly. It is not permanent as is the case after immunization with diphtheria toxin-antitoxin, although, unfortunately, it was assumed by most observers that it would be. Results of this work will be published soon. We are persevering in our efforts, however, to provide a prophylactic measure which will be a fulfillment of all that was hoped for from the original product.

Physicians who have been depending upon the experimental toxin preparation for active immunization of contact cases during epidemics can now use Scarlet Fever Streptococcus Antitoxin, Lilly, and obtain an immunity within a few hours which will be quite as dependable as that secured by three injections of toxin after two weeks or more.

Scarlet Fever Streptococcus Antitoxin, Lilly, is supplied in both the concentrated and unconcentrated forms, 20 c.c. vials of the unconcentrated and 10 c.c. vials of the concentrated. Order as



A-77, Unconcentrated and A-78, Concentrated. Since most of the work with the Dochez serum has been done with the unconcentrated product and more time is needed to evaluate the prophylactic and therapeutic value of the concentrated serum we recommend that your specifications, at present, be for the unconcentrated product, A-77, in 20 c.c. vials.

Supplied through the retail drug trade.

Very truly yours,  
ELI LILLY AND COMPANY.

### TETANUS NOT HOPELESS

While prevention is, beyond all question, better than cure, and has long been considered the only hope in cases of tetanus, a change is coming over the medical mind in respect to the value of antitoxin after the symptoms of tetanus have made their appearance. No longer regarded as useless, the urge is to make the dose adequate, 10,000 to 20,000 units at least, and in the vein or the spinal cord. Some striking cures have been reported from these large doses, followed up by smaller daily hypodermic injections to maintain the antitoxic effect.

Tetanus Antitoxin, P. D. & Co., is recognized everywhere as a standard product, and is available in doses ranging from 1,500 units (for prophylaxis) to 10,000.

Literature on Tetanus Antitoxin and on Chloretone (chlorbutanol), a chemical compound that is given in large doses per rectum to control the muscular spasms of tetanus while the Antitoxin is given for its specific effect, is offered by Parke, Davis & Co., whose advertisement appears elsewhere in this issue.

### A CONTRIBUTION TO THE ADVANCEMENT OF SCIENTIFIC INFANT FEEDING

Within the entire range of medical science, there is, probably, no subject that has received as much careful attention, and has been more thoroughly studied, chemically and physiologically, than the science of Infant Feeding.

Great progress has been made during the past decade, as evidenced by the enormous reduction in infant mortality, which reduction has been due largely to: 1. Education

of mothers. 2. Cleaner and purer milk supply. 3. Scientifically prepared foods.

The Nestle's Food Company have taken a leading part in this work from the very first—and it is a source of intense pride and satisfaction to them that their efforts have been so widely appreciated by the members of the medical profession.

The field of Infant Feeding is really divided into two periods as it applies to feeding during the first twenty-four and most important months of infancy. The First Period—from birth to the seventh month—demands a complemental or supplemental food, that is as easily digested as mother's milk, with as soft and flocculent a curd, and with an analysis closely approximating that of mother's milk.

With the object of meeting this situation, the Nestle's Food Company, after exhaustive experiments in Europe, India and Australia, together with many series of feeding tests conducted in several of the large hospitals in the United States and Canada, submit as their contribution to the advancement of scientific infant feeding, Nestle's Lactogen—the natural food for infants.

Lactogen is a homogenized, scientifically desiccated, full cream cow's milk, manufactured primarily for the feeding of infants from birth to six months of age, who, for any reason, are denied the privilege of breast feeding. It is peculiarly adapted for infant feeding, owing to its close approximation to breast milk in composition, digestion and assimilation, thereby supplying a rapidly increasing demand from the medical profession for a desiccated milk of superior quality and unquestionable safeness, wholesomeness and nutritional value.

Physicians will be interested to know that Lactogen is marketed on a highly ethical basis. No feeding instructions appear on the trade package, and no literature is mailed to the laity.

However, analysis, complete suggestions for the dilution and feeding of Lactogen, together with comparative analyses and caloric values, are mailed physicians upon request.

## Medical Progress

With the cooperation of our associates we propose to publish under "Medical Progress" abstracts from current medical literature of general interest to the

profession. Members of the association are invited to contribute to this Department.

Anderson, W. W., Pediatrics  
Ballenger, E. G., Urology  
Bartholomew, R. A., Obstetrics  
Block, E. B., Neurology and Psychiatry  
Clay, Grady E., Ophthalmology  
Dowman, C. E., Neuro-Surgery  
Eques, M. S., Otolaryngology and Rhinology  
Fitts, Jno. B., Internal Medicine  
Greene, E. H., Surgery

Hodgson, F. G., Orthopedics  
Holmes, Walter R., Gynecology and Female Urology  
Jones, Jack W., Dermatology  
Klugh, Geo. F., Clinical Pathology  
Landham, J. W., X-Ray and Radium  
Pruitt, M. C., Proctology  
Thrash, E. C., Internal Medicine  
Waits, C. E., Surgery

### USE OF A MEAL UNIT DIET IN DIABETES

Ralph H. Major, Kansas City, Kan., (Journal A. M. A., March 14, 1925), uses a very simple formula for estimating diets. The method not only permits of rapid calculation, but also allows a certain standardization of diet, which is time-saving to the dietitian while the patient is in the hospital, and also to the patient when he returns to his home. The principle of this diet is based on giving the patient 30 calories per kilogram of body weight and giving carbohydrate, protein and fat in the ratio of 1:2:3. In making the calculation, the patient's weight in kilograms is multiplied by 30. This gives the total calories necessary for basal maintenance diet. One tenth of this amount of calories is given in carbohydrate, and a division of this figure by 4 gives the grams of carbohydrate necessary. Twice this amount is given in protein and three times this amount in fat. An example of this calculation is as follows: The patient weighs 70 kg.  $70 \times 30 = 2,100$ , total calories daily.  $2,100 \div 10 = 210$  calories in carbohydrates.  $210 \div 4 = 52$  gm. of carbohydrates. The basal maintenance diet for this patient is 52 gm. of carbohydrate, 104 gm. of protein and 156 gm. of fat, daily. A still simpler method of arriving at this calculation is to divide the weight in pounds by 3, which gives approximately the grams of carbohydrate necessary. Thus, a patient weighing 70 kg. weighs 154 pounds. Dividing 154 pounds by 3, we get 51, the grams of carbohydrate necessary. This method of calculation also permits the use to some extent of standardized diets. If the patient is taking insulin, the daily dose is divided so that the greatest amount is taken before the meal containing the largest quantity of carbohydrate. In case the patient is overweight, the diet is calculated for his ideal instead of for his actual weight.

### INTRADERMAL SALT SOLUTION TEST IN LOBAR PNEUMONIA IN CHILDREN

McClure and Aldrich found that the elevation produced by intradermal injection of 0.2 c. c. of an 0.8 per cent. aqueous solution of sodium chlorid became impalpable much more quickly in a group of children having edema than in a group of controls. Jeanette Harrison, Chicago (Journal A. M. A., April 25, 1925), undertook to determine whether in lobar pneumonia the test would show changes in the skin indicative of a tendency to edema and of tissue intoxication, and incidentally to determine what effect, if any, fever has on the tissues' avidity for water. In the tests, the technic de-

scribed by McClure and Aldrich was followed. By this method 0.2 c. c. of sterile 0.8 per cent. aqueous solution of sodium chlorid is injected intradermally under aseptic precautions into the flexor surface of the forearm, or in the leg, or in both, and the persistence of the resulting elevation, as determined by its detection by palpation, is accurately timed. The time for the normal child, over one year of age, is somewhat more than sixty minutes. The twelve patients tested were all acutely ill children ranging in age from two to fourteen years. In none was there any edema demonstrable by pitting. In lobar pneumonia in children: There was a considerable shortening of the disappearance time of intradermally injected salt solution. The crisis had no immediate effect on the length of the disappearance time. After the crisis, the return to a normal disappearance time was usually slow. It is suggested that this effect on the disappearance time indicates an intoxication of the tissues, which is more persistent than is ordinarily considered to be the case.

### HYPERPNEA AS METHOD OF DIAGNOSIS

L. E. Grimberg, New York (Journal A. M. A., May 16, 1925), undertook to try his method on patients suffering from purely functional conditions. He selected five patients with an established diagnosis. The cases were classified as hysteria, anxiety neurosis and psychoneurosis. All the patients were women, their ages ranging between 18 and 30. The results obtained are briefly reviewed. Hyperpnea produces in the neurotic, in addition to involuntary movements of the fingers, tetany and emotional outbursts. In hysterical patients, the outbursts are identical to the hysterical attacks of such patients. In organic cases it increases the symptoms, and may serve to establish (in some patients) the organic or functional character of the condition. The method is of use in patients suffering from hysteria with major attacks or from epilepsy who are unable to give a clear description of the attacks. In such patients, the method will reproduce the attack. Hyperpnea should be used cautiously in patients suffering from thyroid disturbances.



### A CASE CITING AN ADDITIONAL USE FOR BELLADONNA

In the case reported by Charles E. Haines, New Rochelle, N. Y. (*Journal A. M. A.*, Oct. 18, 1924), belladonna not only relieved a condition diagnosed as vagotonia, but supplemented the roentgen-ray in assisting at an important decision with regard to the therapeutics. An apparently healthy man, aged 27, came to me. The patient complained of a sense of epigastric fulness and distress beginning immediately after eating and persisting for an hour or more. The distress was not relieved by sodium bicarbonate, nor had it shown periods of remission, as pain from an ulcer tends to do. Roentgen-ray examination suggested carcinoma of the stomach. The patient was put on tincture of belladonna, 8 drops, three times a day after meals for three days, until the tongue was slightly dry and the vision a little blurred. Then another series of roentgenograms was taken. There was no suggestion of any lesion. The patient was given tincture of belladonna, 6 drops, three times a day after meals for one week, after which the dose was gradually reduced until it was discontinued at the end of one month. The patient has not had any distress during the two years since the drug was stopped.

### PRODUCTION OF LIVER NECROSIS

Reuben Ottenberg and Harold A. Abramson, New York (*Journal A. M. A.*, March 14, 1925), report on experiments undertaken primarily to determine the upper safe limits of dosage of tetrachlorophenolphthalein, and tetrabromphenolphthalein. The doses needed to produce severe symptoms and liver lesions were enormously larger than those used in the tetrachlorophenolphthalein test for liver function (0.005 gm. per kilogram). While the amount of tetrabromphenolphthalein used for gallbladder visualization (0.1 gm. per kilogram) is also safely below the toxic dose, the margin is not so large, and suggests the necessity of caution in cases in which the liver parenchyma is already damaged by disease.

### DUODENOGRAM: NEW METHOD OF VISUALIZING ENTIRE DUODENAL CONTOUR

Jacob Buckstein, New York (*Journal A. M. A.*, Feb. 14, 1925), passes an intestinal tube just beyond the duodenojejunal junction. The distal 8 inches of this tube is perforated by numerous small openings. A suspension of bariu mis injected through the

proximal end. When this suspension reaches the distal end, it escapes through all of the numerous perforations at practically the same time, and fills the entire duodenum in an unobstructed, isolated and homogeneous manner. This simple method obviates the necessity of employing any special apparatus or of producing unphysiologic distal obstruction, in filling the duodenal curve. The method is of value for a roentgen-ray study of the normal duodenal curve and of pathologic variations.

### TUMORS OF THE TESTIS, SIMULATING EPIDIDYMITIS

Neoplasms originating in the epididymis, although rare, certainly do occur; it is also apparent that tumors originating in the testis may and sometimes do involve chiefly the epididymis, especially in the early stages, and give rise to symptoms simulating a subacute or chronic inflammatory process, such as tuberculosis. That this deceptive trait is not confined to one class of tumor is shown by the three cases cited by J. D. Barney, Boston (*Journal A. M. A.*, Feb. 24, 1925), of which one was a sarcoma, one an embryonal carcinoma, and one an embryonal cardioma combined with teratoma. Barney is of the opinion that when there is any doubt whatever as to the diagnosis, an immediate exploratory operation on the scrotum can be done under local anesthesia, that it involves but little confinement to bed, and that it is practically, if not actually, without mortality, fully justifies the procedure, especially when, as is well known, an error in diagnosis may be so costly.

### DIVERTICULA OF THE URINARY BLADDER

Observations made by R. V. Day and H. W. Martin, Los Angeles (*Journal A. M. A.*, Jan. 24, 1925), lead them to conclude that diverticula of the urinary bladder with marked clinical symptoms are nearly always associated with prostatism, either hypertrophy or bladder neck contracture. Rarely the symptoms may be caused by uterine obstruction. Surgical relief of the obstruction is necessary in almost every instance. Excision of the diverticulum is indicated in the case of well developed sacs of moderate or large size, if drainage is poor. Advanced degenerative changes in the cardiovascular system and kidneys may make inadvisable excision of the sac itself, unless the cystitis is intolerable.



### SIGNIFICANCE OF THE COLLOIDAL PROPERTIES OF GELATIN IN SPECIAL DIETARIES\*

An examination of the dietetic possibilities of gelatin from a chemico-physiological standpoint reveals a number of properties which should make this unique food product a valuable addition to special dietaries, particularly those in which milk forms the sole or major portion. In such dietaries gelatin functions as a protein food to the extent of the utilization of its amino acids by the body and in addition possesses marked activity as a protective colloid and emulsifying agent. Practical observations in clinics and hospitals as well as experimental work in laboratories indicate that these characteristic properties of gelatin as a colloidal substance exert a most significant influence in promoting digestion and absorption of certain types of foods.

The importance of this colloidal activity of gelatin where fed in conjunction with dairy products has been demonstrated by the writer in feeding tests with the albino rat. Shortly after weaning the young from several litters were divided into two groups; one group received pasteurized whole milk as its sole diet, the other pasteurized whole milk containing one per cent of gelatin. Observations extending over a period of six months showed that the growth and physical well being of the group fed on gelatinated milk was markedly superior to animals fed on the plain milk diet. The increased growth was accomplished on smaller food consumptions. In fact, during the early growth period for equivalent gains in body weight the animals on gelatinated milk consumed about 23 per cent less food than the group on plain milk.

Another striking illustration is found in the writer's experiments with ice cream. Over a period of seven weeks it was observed that a group of rats fed on an exclusive diet of ice cream containing one per cent of gelatin gained no less than 25 per cent more in body weight than was the case with their brothers and sisters whose diet was plain ice cream.

For equivalent gains in body weight, the food consumptions of the group fed on the gelatin-containing ice cream were much less. Smaller percentages of gelatin resulted in proportionate improvements. It is important to note in this connection that the better nutritional status of the gelatin ice cream group after a number of months on the diet was reflected in continued health and growth, and in increased bone development and reproduction in several cases.

It should not be presumed that the observed improvements of the dairy products are due entirely to the added protein value of the gelatin, but possibly more to the protective colloidal and emulsifying effects that it confers. The digestive processes are essentially colloidal phenomena, whereby fats, carbohydrates and proteins are ingested in the colloidal conditions and changed by the various enzymes to degradation products capable of absorption by the body. To accomplish the formation of these simpler substances, the enzymes must come into intimate contact with the food particles. If, perchance, the food particles are present as large tough masses, as is the case with cow's milk coagulating under the influence of hydrochloric acid and rennin in the human stomach, the contact surface of the enzymes with the food is limited and gastric digestion is delayed or impaired. Various specialists have described experiments in vitro as well as with humans which show that the coagulation of cow's milk by acid and rennin is prevented or modified in character in the presence of relatively small amounts of gelatin. This effect is spoken of as protective colloidal action and it is interesting to note that gelatin is one of the most efficient of all known protective agents. Gelatin is also a good emulsifying agent and it is quite probable that it aids the secretions of the alimentary apparatus in the emulsification of fats.

In discussing the digestibility of milks, Chapin says that those animals whose stomachs form the larger percentage of the digestive tract and their digestion is largely gastric produce milks that form tough curds, as for example, the cow. In contrast is the human, whose stomach forms only about 20

\*By Thos. B. Downey, Ph.D., Senior Industrial Fellow, Mellon Institute of Industrial Research, University of Pittsburgh, Pittsburgh, Pa.

per cent of the digestive tract. Human milk curdles in light flocculent masses. It has been pointed out by Alexander that human milk contains a natural protective protein in large amount, which is present in small amount in cow's milk. It would seem that the addition of such a protective agent as gelatin to cow's milk would make it particularly suitable for infants, and such has been found to be the case, as is testified to in pediatric literature.<sup>1</sup>

In like manner, gelatin has been shown to be of value in other dietaries composed largely of dairy products. For example, Hawk reports that the addition of gelatin to the milk-egg diets of tuberculosis patients resulted in decided nutritional improvements with the majority of the cases tried.

The experiments described suggest the advantages that are to be derived by the utilization of gelatin in other dietaries. The protective colloidal and emulsifying action of gelatin promotes the digestion and absorption of various types of foods. It is also misleading to assume that gelatin as a protein is of insignificant food value.

Feeding tests by McCollum and by Osborne and Mendel have shown that with certain cereal grains gelatin is exceptionally well utilized, presumably through its high content of the amino acid lysine. Also, with milk proteins gelatin is of value, as has been found by Sure. In combination with milk in the liquid form, it is believed, however, that the colloidal properties are of greater significance.

1. See, for example: Jacobi, "Industrial Diseases of Infancy and Childhood", 1887, p. 79; Starr and Westcott, "Diseases of Children", 1900, 23; Griffith, "The Care of the Baby", 1908, 386; and Friedenwald and Rubrah, "Diet in Health and Disease", 1923, 295, 466. On the utility of gelatin in chronic intestinal infection, see Herter, "Infantilism from Chronic Intestinal Infection", 1908, 101.

### CONGENITAL LYMPHANGIETATIC EDEMA

Congenital lymphangiectatic edema, as in the case reported by Harold O. Ruh and Leon H. Dembo, Cleveland (Journal A. M. A., May 9, 1925), has resisted all forms of treatment tried, and has shown no tendency toward improvement. A definite etiology has not been established, but the evidence presumes a congenital defect in the lymphatic system. This is a rare form of edema, and is to be differentiated from cases listed under the term congenital elephantiasis.

### BOOKS RECEIVED

*Clinical Features of Heart Disease*—By LeRoy Crummer. Price \$3.00, net. Paul B. Hoeber, Inc., 67 E. 59th St., New York City, Publishers.

*Medical and Surgical Report of the Roosevelt Hospital, New York*—(Second Series—1925). Price \$5.00. Paul B. Hoeber, Inc., 67 E. 59th St., New York City, Publishers.

*Compend of Gynecology*—By Well. Fifth Edition. Revision made by Dr. William Benson Harer, Instructor in Obstetrics, University of Pennsylvania. Contains 167 illustrations and 371 pages. Price, in cloth, \$2.00. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia, Publishers.

*Surgical Clinics of North America*—February number. These Clinics are issued every other month. W. B. Saunders Co., West Washington Square, Philadelphia, Publishers.

*The Health-Care of the Baby*—A handbook for mothers, nurses, and physicians. By Louis Fischer, M. D., consulting physician to the Willard Parker and Riverside Hospitals, Medical Director of the Infanterium and to the Heckscher Foundation and Nursery, New York City. 15th Edition, completely revised, rewritten and reset. 267 pages. Price, cloth, \$1.00, net. Funk & Wagnalls Co., New York.

### PITUITARY EXTRACT

There are a good many pituitary extracts on the market, scarcely two of them alike in activity and, consequently, dosage. In fact the same preparation may differ at different dates by as much as 50 per cent if improperly made, carelessly exposed to the light, or kept too long under even favorable conditions. Pituitary extracts should be dated, and the ampoules should be kept in their cartons till needed. It goes without saying that the date stamped on the package should be consulted.

A pituitary product that has won an enviable reputation because, for one thing, it was the first in the field, and for another because the standard of activity applied to it is such as to make the average obstetric dose  $\frac{1}{4}$  to  $\frac{1}{2}$  cc (4 to 8 minims), is pituitrin, P. D. & Co. Pituitrin is tested, we are told, by two methods, to demonstrate, respectively, its effect on blood-pressure and its effect on uterine tissue.

A new booklet on "Pituitary Therapy," covering not only Pituitrin but preparations of the anterior lobe of the pituitary body, and of the whole gland substance, is offered to physicians by Parke, Davis & Co., Detroit, Michigan.

## The Selection of a Physician.

The selection of a physician for an operation or as a family doctor, is usually made with some care. We consult those who have employed physicians and are governed largely by their recommendations. But having selected a physician, we follow his advice. We trust him even to the extent of submitting to operations that may have serious results.

The point is, we trust THE MAN WHO KNOWS.

Now, doctor, the institutions and the firms advertised in this Journal were carefully investigated before their announcements were printed here. The medicinal products were submitted to laboratory tests before they were accepted by the Council on Pharmacy and Chemistry.

On the same principle that patients trust you about matters with which you are informed, so your publishers urge you to trust their judgment and buy goods from the advertisers who are admitted to these pages. Other considerations being equal, you should give your advertisers PREFERENCE because you know they are believed to be trustworthy. Don't speculate or experiment! Trust the APPROVED firms and goods!

## THE ATLANTA GRADUATE SCHOOL OF PHYSICIANS and SURGEONS

ATLANTA, GA.

*Announces—*

**Short Term Post-Graduate Courses in Medicine and Surgery**

*Special Courses*

UROLOGY INCLUDING  
CYSTOSCOPY

Prof. Montague L. Boyd

GASTRO-ENTEROLOGY

Prof. J. Clarence Johnson and as-  
sociate Prof. Trimble Johnson

**Classes limited to 10**

*For Information Address*

**THE PROCTOR**

Atlanta Graduate School of Physicians and Surgeons

101 North Butler St., Atlanta, Ga.



# THE JOURNAL

## OF THE

# MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL PROFESSION OF GEORGIA

PUBLISHED MONTHLY under direction of the Council

Volume XIV

Atlanta, Ga., July, 1925

No. 7

## Original Articles

### MAKING A DIAGNOSIS\*

R. M. Harbin, M.D.,  
Rome, Ga.

When I accepted the invitation of your Chairman to meet with you, I felt an apology was due, inasmuch as I had nothing new in diagnosis to offer. So I only come to you as a fellow student of old methods, and if I could convince you that all of us have been negligent of the resources that we have in hand I should feel that this discussion had not been in vain.

Genius has been defined as the ability to take infinite pains and in our common weal of mediocrity we are not debarred from participating in some of the fruits of genius according to this definition, for we all have an ever beckoning privilege to take greater pains in our efforts of diagnosis. In connection with this statement I have just reviewed a previous report of seventeen cases of error in diagnosis occurring in 500 laparotomies and found that 50 per cent of these errors in diagnosis could have been eliminated by more carefully taken clinical histories and by more thorough physical examination. While perhaps our errors in diagnosis may be negative as to harm, there are occasions for positive dangers from operative treatment. Whether a surgical abdomen be this or that, the question of location of the pathology is one of academic importance. To remove an acutely diseased or normal gall bladder through a mistaken diagnosis is more dangerous than removing a chronically diseased organ. Haggard says (Ohio Medical Journal, 1924-XX-

613): "It is unwise to remove a gall bladder that is not definitely diseased, and still worse to drain it." I was called in an emergency to see a man 66 years old, with acute abdominal pain, and expressed doubt as to diagnosis. The attending physician with a consultant subsequently diagnosed acute appendicitis. Through a right rectus incision, it was discovered to be a case of acute cholecystitis with gall stones which necessitated extending the incision higher for gall bladder drainage. Because of troublesome post operative vomiting, the stomach douche was applied and straining broke the sutures in such a long incision causing partial evisceration. This contingency seemed to contribute to, if not, the cause of his death. I have second-hand knowledge of a similar error in diagnosis in which post operative hemorrhage caused death. While an ill advised operation may not be directly responsible for an unfavorable result, it may occasionally lead to some complication that would be fatal.

In view of the fact that efforts of diagnosis so much concern organs more or less vestigial in character, it is well to bear in mind that 61 per cent of all laparotomies for disease concern the appendix giving directly 41 per cent of death while 5.2 per cent of operations and 7.2 per cent of deaths relate to the gall bladder. These figures have been prepared from a review of 2,472 laparotomies for diseases.

In making a diagnosis it is in the first place necessary to clear the deck temporarily of preconceived opinions of the patient and quoted statements of medical men. In other words, open mindedness should be stressed

\*Read before the Clinical Society of the Georgia Baptist Hospital, Atlanta, April 21, 1925.

by assuming no knowledge whatever of the patient's condition and then subsequently bring to bear all the collateral information available. A physician's long familiarity with a patient's condition tends to cursory methods. Clinical history records should follow the lead of chief symptoms and then ramify to contributory causes. There is logic in brevity when pursuing a definite aim in methods of diagnosis, while the massing of unconnected clinical evidence would be confusing. That rare product we call clinical judgment is the intuitive reflex from years of experience from failures as well as successes backed by painstaking methods, applied to an individual case. The higher art of diagnosis is not attained so much from correlating evidence as interpreting symptoms. It would seem superfluous to go in great details of a description of methods for a complete physical examination, yet many of our errors happen from a lack of these details. Sometimes we feel so sure of a diagnosis that we short circuit many of our routine methods and therein lies a liability to error. Suffice it to say that the patient's clothes should be entirely removed in a comfortable room. One of our errors in diagnosis happened in operating for gall bladder disease where the patient had tuberculosis of the spine. A palpation of the spine would have safeguarded this error. In such a great counting house for errors in diagnosis as the Mayo Clinic, a staff member once remarked to one of my colleagues that he did not see why surgeons generally did not do a routine of palpating the spine.

A few days ago we made a diagnosis of empyema of the gall bladder which proved to be an abscess of the appendix. There was no history of gall bladder trouble.

Laboratory methods should be applied more or less routinely because in most instances certain examinations require to be made in order to determine whether they are needed.

A rare poise of judgment is necessary to avoid a top heavy routine.

There are certain examinations of the blood that must necessarily be more or less routine. We would hardly ever discover the necessity for a blood examination for an early

diagnosis of pernicious anemia or leukemia, and the same is true of the Wassermann. A tentative laboratory examination may become simply a lead towards a definite line of investigation. Positive readings at times from urinalysis and sputum examinations should be looked upon as indicating terminal or secondary pathology in which the original disease has lasted for some time. On the other hand, a negative urinalysis may be obtained in the presence of gross pathology that causes obstruction of one ureter and an encapsulated tubercular lesion of the lungs may show a negative sputum. We all recognize the value of leucocytic readings in acute conditions where leucocytosis is well in advance of clinical symptoms. On the other hand, a normal leucocytosis with active febrile conditions usually excludes localized infections.

The diagnostic armamentarium is incomplete without an X-Ray equipment but a note of warning should be sounded that the method of percussion and auscultation may become a lost art because of the ever ready fluoroscopic technique. The value of these methods has for its basis by dealing with phases of density. The use of the fluoroscope is a great time saver and because of its simplicity should become a routine procedure in chest diagnosis in order to determine the necessity of a plate record. But for the fluoroscope we would rarely be able to discover the degree of dilatation of the aorta which so frequently results from hypertension.

Discussion of X-Ray methods would be too voluminous for this occasion, but we would urge that the word interpretation should ever become a ding-dong phrase. For this reason an X-Ray plate should frequently have consultation. It requires intelligent direction to refer patients to the strict specialists.

When one member of a staff has completed a record of diagnostic data a second colleague should review the record and make a general examination of the patient for the purpose of a consultation. It requires a trained association of personalities of physicians to avoid duplication of methods of investigation so as to be on the alert to recognize certain reciprocal omissions.

While the joint method of study may not always be practicable it constitutes a *sine qua non* of a medical ideal. Differences of opinion should be and usually are wholesome, but unless safeguarded they become destructive instead of constructive in tendency, and this contingency hinges on the personnel of the consultants. The right of action should finally redound to the leading party of the examination after all differences have been filed in the consultation. If confidence in one's opinion survives under these circumstances, it becomes the best of diagnostic ability a physician is capable of giving.

These cursory remarks are offered for the purpose of demonstrating the enclosed table. It may require somewhat of a stretch of the imagination to reduce a study in diagnosis to a chart demonstration but the effort may prove worthy by impressing the value of a systematic attempt of procedure. We have taken 1,000 consecutive case records in which the diagnosis of the primary disease was noted. The classification of diseases was made according to regions of the body and the relative values of the different methods of diagnosis are shown in respective columns.

General experience has shown that the family physician makes correct diagnosis in 80 per cent of their patients without consultation and the remainder requires a close study by the various specialists. In this series the great majority were referred patients and even in these the physical examination and clinical history methods were respectively conclusive in 42 per cent and 30 per cent of the whole. That is in 303 abdominal diseases a physical examination was positive enough for action in 150 cases, while the same conclusion could be arrived at in 151 cases from the clinical history method. While a positive diagnosis now seems warranted it may be expedient to corroborate these findings by other methods. For instance, if we have a 50 per cent typical history of acute appendicitis that gives a marked degree of leucocytosis after other conditions are excluded, we should assign the laboratory say 50 per cent of the share for making a diagnosis. There were 32 cases of abdominal disease where the surgeon could consistently advise treatment on laboratory findings alone.

The same logic may be applied to the X-Ray method. The object of such a method of study is to stimulate us to inquire how we arrive at certain conclusions and then the details of procedure would serve to be emphasized. Of course, the diagnosis of surgical diseases within the abdomen finds a ready test in the operating room and in a recent review our errors in diagnosis were rated at 3.4 per cent.

The diagnosis of a need for exploratory operation should be approached very critically and percentages of same should not be allowed to run high and our record has been placed at 1.2 per cent.

If I may be allowed to offer a criticism of customs that be, I would urge a protest against the too frequent use on the part of physicians of dogmatic statements to the patients, "I don't know," which may be offered after a critical examination. It is unwarranted harsh psychology for the sensibilities of the uninformed patient and the fact that a thorough examination does render knowledge of the patient's ailments should rebuke such a dogmatic statement which from the standpoint of scientific accuracy may be true. We should humanize our medical opinions to patients without compromising the truth in any degree. Of course, it is understood that no diagnosis should be offered that is not entirely warranted by the facts of the case. Undue scientific frankness from the standpoint of the patient seems to preclude contingencies and all further interest in the case.

We might do well to refer to certain specific conditions that create hazards in diagnosis. It may be remarked in passing that it requires a critical examination to determine that a patient is sound, and in a recent review of 1,776 case records we found 20, or 2.2 per cent in good health. There are perhaps greater hazards to correct diagnosis in the female pelvis than any region of the body. Foremost reason for this probably obtains because of a preconceived opinion among patients, often shared by physicians, that a great variety of nervous symptoms proceed from disorders of the female generative system. Our errors in diagnosis have been in this class of abdominal surgery 8.8



per cent. In the first place, it is difficult to detect actual pathology by the usual method of examination and in the next place difficult to say when such pathology when present is the cause of symptoms. It is conceded that many cases of marked disease of pelvic organs produce little or no discomfort. So far as our own experience is concerned, we are becoming more and more conservative in advising pelvic surgery for border line cases.

While experience may vary in different communities, we find a large number of patients (20 per cent) requesting examination for suspected tuberculosis, who only show a subnutrition even among the well-to-do class. While we recognize that incipient lesions of tuberculosis cannot always be detected by any examination, in the majority of cases that shows impoverishment of hemoglobin and red cells that would be sufficient reason for a diagnosis of subnutrition. A tubercular lesion sufficient to cause a marked degree of emaciation should be demonstrated by the usual methods of diagnosis. Unscientific as it may seem, the method of diagnosis by exclusion finds justification in the absence of a better procedure. At present two classes of the more common diseases are necessarily dependent on this manner of study, and they are chronic appendicitis and infected tonsils. We all recognize that the gross pathological appearances of appendicitis, both acute and chronic, give no clue to the activity of symptoms. Inasmuch as symptoms of appendicitis most usually proceed from obstruction of the lumen, the X-Ray method would be of little value. The only reliable method of verifying the diagnosis of chronic appendicitis is by a follow-up report one year later,

and in a recent review of 62 cases 75 per cent reported cures.

If there ever was a romantic story of diagnosis, it is that of infected tonsils which occasionally cannot be discerned by any method of inspection or examination or even by laboratory tests after removal. So at present we are limited to the method of diagnosis by exclusion which must be exhaustive and corroborated by a follow-up report after several years. Empirical as this may seem, years of experience have proved the wisdom of the method. It requires effort to believe that infected tonsils may cause optic neuritis in childhood and thirty years later be a cause for hypertension. We have clinical records that seem to corroborate this statement.

Mrs. Blank, stout multipara, 42 years old, had obstinate headaches of the migraine type since childhood and last few years has been having palpitation of heart, X-Ray showing a marked hypertrophy, blood pressure 175 systolic and 100 diastolic, with some dyspnoea. No history of throat trouble whatever and tonsils reported entirely negative by three or four specialists in different cities. Tonsillectomy advised on empirical grounds and tonsils were small and embedded. Her present condition after these six years shows entire relief of symptoms, normal blood pressure and only an occasional headache. Of course, there are young patients with a high degree of hypertension where tonsils show evidence of infection.

We do not believe that infected teeth produce systemic disturbances so often as was believed four or five years ago.

### DIAGNOSIS OF PRIMARY DISEASES IN 1000 CASE RECORDS

	%	Abdomen	Head	Neck	Resp.	Cardiac	Urinary	Bone	Nerve	Gen.	Misc.	Cancer	Total
					Tons.								
Organic .....	100	303	23	11	129	36	97	15	119	171	78	18	1000
Functional .....		273	23	11	127	29	94	15	17	108	70	18	785
Physical .....		30	0	....	2	7	3	0	102	63	8	0	215
Exam. Method .....	42	150	5	11	86	2	34	2	110	59	10	....	....
Clin. Hist. Method.....	30	151	2	....	9	1	....	....	1	43	11	1	....
Laboratory .....	11	32	0	....	....	13	9	5	....	2	3	....	....
X-Ray .....	9	20	9	....	54	....	32	....	....	....	....	....	....
Cystoscopic .....	3	....	....	....	....	1	....	....	....	6	3	....	....
Head Sinus .....	.03	....	3	....	....	1	....	....	3	6	3	....	....
Teeth .....	1.8	....	10	....	....	3	19	7	11	23	34	12	384
Operation advised .....		196	15	7	51	3	8	7	11	21	34	12	346
Operation done .....		173	13	7	47	....	....	....	....	....	....	....	....

NOTE: There were diagnosed 708 collateral diseases.

## A SKETCH OF THE EARLY HISTORY OF MEDICINE AND SURGERY IN GEORGIA

J. L. Campbell, M. D.,  
Atlanta, Ga.

"The Moving finger writes; and having writ,  
Moves on; not all thy pity nor wit  
Shall lure it back to cancel half a line,  
Nor all thy tears wash out a word of it."  
Omar.

In order to visualize the problems with which our pioneer professional fathers had to deal, it is necessary to review some of the social and professional conditions in the mother country at the time of the colonization of Georgia. No branch of history portrays so well the struggle through which the human race has passed to reach its present cultural and social position as the history of medicine. Just as medicine and Christianity have advanced, the sick and poor have received better attention, better almshouses and better hospitals have been built, the government has had better armies, business has been able to push industrial enterprises into hitherto uninhabitable land, and an ever increasing span of life has been added to the human race. In the beginning of the eighteenth century, sick and ailing humanity were cared for by three distinct and totally different classes of individuals: physicians, surgeons and midwives.

The physicians or men who then practiced what is today known as internal medicine were, as a rule, well educated, refined and cultured gentlemen. They frequented the coffee houses and other fashionable resorts and kept company with poets and statesmen, for many of them were authors of no mean ability.

Surgery had been in the hands of the barbers, the executioners, the strolling bone setters and "vagabond surgeons" for generations. Most of them were unrefined and uneducated men of the servant class. Occasionally a great man, as Ambroise Pare in the 16th Century, rose from among their ranks. He was the most distinguished surgeon of the Renaissance period and it has been said of him that he was the "greatest military surgeon of all times." Very little

operating was done because there were no anesthetics or other methods of relieving the suffering of the patient, so that people shrank from an operation as from something deadly.

The hospitals were death traps and the wards were dark and filthy, and filled with vermin. Even in Paris and Vienna the patients were often forced to lie on the floor or were crowded four to six in one bed. No effort was made to separate medical from surgical, or clean from infected cases. The ventilation was frequently so bad "that attendants and inspectors would not enter a ward without a sponge dipped in vinegar held to their faces." The average mortality was 20% and recovery from a surgical operation was, in the nature of things, a rarity.

Obstetrics was in the hands of women known as "midwives," even more ignorant and unrefined than the surgeons. The morbidity and mortality in this department was appalling. Medical men had attended obstetrical cases in Spain and elsewhere on the continent, but in England they were just beginning to do such work—William Hunter being among the first to take it up. When the midwife was at the height of her glory "a woman in normal labor had about an equal chance between puerperal fever and eclampsia; in difficult cases she was butchered to death if attended by a 'Sairy Gamp,' or a 'vagabond surgeon.'"

However, the era of spiritual and intellectual freedom, which began with the reformation, was progressing; the sacrifices of the heroes and martyrs of the 17th Century were beginning to bear fruit in the scientific realms.

Harvey had discovered the circulation of the blood; Van Leenwehoek in Holland and ground lenses of such high power that he was able to see and demonstrate the striae of voluntary muscle fibres. He had also seen and described the red blood corpuscles and various forms of micro-organisms. Marcello Malpighi in Italy had completed his work in embryology and with the aid of Van Leenwehoek's microscope had discovered the bodies which bear his name in the kidneys and spleen.

The investigations of these and others opened the way for the advances in scientific medicine and surgery soon to be made by Cheselden, Charles White, Percival Pott, William Hunter and his distinguished brother, John, whose splendid work in anatomy, physiology and clinical medicine, placed surgery in the field where it belonged. It was due to the efforts of these men that medicine and surgery became more closely allied: but it was not until 1745 that the surgeons were completely separated from the barbers by the enforcement of a law prohibiting anyone from practicing surgery in or within seven miles of London or other incorporated cities, who was not licensed by the Committee of the Surgeons' Corporation. The London Corporation later became the Royal College of Surgeons of London.

Although there were medical chairs in some of the great universities, medical education was acquired by apprenticeship to a preceptor with perhaps a short course of lectures in clinical medicine.

In 1740, eight years before John Hunter was born and twelve years before Oglethorpe sailed for America, William Cheselden, who was destined to become John Hunter's clinical teacher, began at St. Thomas' Hospital, the first course of clinical lectures ever given in England.

Jenner, who gave to the world vaccination as a prevention for smallpox, had not yet been born. No one had any knowledge of pathology and very little of physiology. No one knew that the tissues of the body were made up of cells nor was this fact discovered for more than 100 years. It was not known that the various forms of infections are due to the minute bodies seen and described by Van Leenwehoek. His essays were carefully filed among the archives of the Royal Society, only to be remembered later when Robert Koch and Louis Pasteur demonstrated that these organisms play such an important role in causing human ills.

The 18th Century was the age "par excellence" of the successful quack and secret nostrum. So prevalent was this condition that George Crabbe wrote—  
"From the poor man's pay

The nostrum takes no trifling part away."

"Quackery, if not universal, was at least universally successful." For example, Sir William Reed started life as a tailor but soon tired of so tame an existence and hired some one to write a book on diseases of the eye under his name. He also engaged a press agent to laud him, opened a fashionable office in the Strand, and soon became famous. He was knighted by Queen Anne and favored by George I. This man was only one of hundreds of others, equally as bad, who obtained fame and fortune by pleasant gossip in the coffee houses and other fashionable resorts.

In the Colonies, as well as in England, the remedies used for almost all conditions were blood-letting, leeching, poultices, and last but not least, purgation, often with mercurials until salivation was produced, which frequently gave more distress than the original malady.

Among those who sailed for America with General Oglethorpe in November, 1732, was Dr. Noble Jones, who "was bred to the practice of physie which he followed in his native country." The colonial physician did not confine his activities to the practice of medicine but frequently participated in the affairs of the province. Dr. Jones was the Recorder or Clerk of the first Court held in Georgia, and a little later was commander of a garrison. Dr. Patriek Graham "was apothecary to the Trustees, counsel to Governor Reynolds, and he and Dr. Noble Jones, among a few others, were owners of a considerable quantity of land near Savannah."

In July, 1733, a large number of Hebrews came to Savannah. Among them was a distinguished physician, Dr. Samuel Nunez, a native of Lisbon, who was compelled to leave his native land to escape the torture of the Great Inquisition. He hoped to find in the new colony a home where he could worship God according to the dictates of his own conscience, but Jews were so unpopular in Savannah that he was compelled to leave the colony.

Dr. Noble Wimberly Jones was the next physician to attract attention. He came to



the colony with his father, grew up in his office and naturally became his successor. There is no record of his attending school or college, yet he is described as an "educated and cultured man." The first public service he rendered the colony was at the age of fifteen, when he served as Cadet in General Oglethorpe's army on St. Simons Island during the campaign against the Spaniards and Indians. While on the island he was promoted and performed the double duty of officer and surgeon.

As he grew older, he became interested in Colonial politics and vigorously opposed the policy of King George III. He was elected to the Assembly several times, and was made speaker of the House on more than one occasion. When the Continental Congress was organized, he was elected to Georgia's delegation, but was unable to attend on account of the ill health of his aged father who died in 1775.

When Savannah fell into the hands of the British, Dr. Jones was forced to move to Charleston, where he began to practice medicine. Later he was captured and sent to St. Augustine, Florida, where he was treated with great personal indignities until through the influence of friends he was exchanged and sent to Philadelphia. As soon as it became known in Georgia that he was there, he was added to the Congressional delegation. He soon became acquainted with Dr. Rush, who was of great assistance to him for the British had confiscated all he had accumulated in and around Savannah.

When peace was restored, he returned to Charleston, where his family was living, but soon left there and re-established himself in his native town, where he was affectionately known as the "Morning Star of the Revolution."

In 1804 he helped to organize the Georgia Medical Society (now Chatham County Medical Society) and was its first president. "He died on the 9th day of January, 1805, honored by the community as an honest man, a sterling patriot, and a skillful physician."

In 1721, Drs. Patrick Tailfer and Hugh Anderson wrote a description of the settlement at Savannah, and criticised the location of the colony because of the unhealth-

fulness of the climate. Drs. John Irvin and Thomas Young were contemporaries of Dr. Noble Wimberly Jones and were incorporators with him of the Georgia Medical Society. They were both men of high professional standing, refinement and liberal education.

Dr. Nathaniel Brownson, of Liberty County, was not only a good physician, but an enlightened statesman and a true patriot. He was a surgeon in the Revolutionary Army and served the State as Governor in 1781. When the war was over he retired to his home where he practiced his profession until his death November 6, 1796.

Dr. Lyman Hall was born in Connecticut in 1725 and was graduated from Yale in 1747. He came South with a party of immigrants from New England and settled first in South Carolina, but in 1752 moved to Sunbury, St. Johns Parish, now Liberty County, Georgia. In addition to being a successful practitioner of medicine, he was active in colonial politics and did much to secure the co-operation of Georgia with the other colonies in their struggle for independence. He was one of the three congressional delegates from Georgia to sign the Declaration of Independence. He remained in Congress until the British invaded Georgia in 1780, when he returned to find them in possession of all his property. He at once began to devise means of expelling them from the province. As a result of his activities and successful political and military work, he was elected Governor in 1783. "He was, in all relations of life, a most useful and exemplary member of society. He died in Burke County, October 19, 1790."

In 1760, Dr. William Day, who lived near Augusta, was mentioned by Colonel C. C. Jones as a man of influence. He had a large practice but found time to act as one of the tax assessors of Richmond County. Dr. Thomas Ford also of Richmond County enjoyed the distinction of having been paid the largest professional fee on record in our State: he was voted Lbs. 20,105 by the Assembly for "attending the people of the province wounded by the Cherokee Indians." In 1773, Dr. Andrew Johnson was paid Lbs. 3 by the Assembly for examining the body of William Miller who had been killed about twenty miles above Augusta.

Dr. Johnson and two contemporaries, Drs. Francis Falliotte and Thomas Taylor, were Royalists. At the beginning of the Revolution they were expelled from the province, but in 1785, Dr. Johnson was allowed to return and resume his practice on the condition that he would pay a fine of 1 per cent of his property and forfeit the right to hold office for fourteen years. This was a light penalty, probably due to the influence of his close personal friend, Dr. Cornelius Dysart, a man of large fortune living about three miles from Augusta on the Washington Road. There is no record of the others having been allowed to return.

"Drs. Jacob V. Egbert, James Houston, James B. Sharp, Benjamin Tilard and John G. Wright, physicians of Georgia, served as surgeons in the Continental Army." Drs. McKimner and David Brodie served in the hospital department of the Georgia Brigade of the Continental Army. "Dr. David Brodie was in the battle of Midway, where General Scriven was killed, and attended that officer in his dying moments. When the British captured Savannah, he was taken prisoner and placed on a prison ship. The close confinement on board soon terminated his life."

Serving as surgeon's mates in the same Department of the Georgia Brigade were Drs. Wood, Adam Alexander, Nathan Brownson, James Houston, Thomas Davenport and Frederick Ridgby. We have already mentioned that Dr. Brownson served the province as Governor in 1781, and later he was prominent as a member of the first State Senate.

Georgia kept from 750 to 1,000 troops constantly in the fields during the Revolution, but these, even with the help of some of the South Carolina troops, were unable to protect the province from the ravages of the British and Tories. Many of the medical men had to perform the double duty of line officer and surgeon.

We have thus far covered a period of 50 years, during which time the population had increased from 135, who came from England with General Oglethorpe, to more than 17,000 white citizens. When peace was estab-

lished a great horde of immigrants flocked into the newly opened country so that in 1790 there were a little more than 82,000 living in the State. A large number of these people were shiftless and ignorant. There were no Churches or school houses outside of Savannah, Augusta and a few of the larger centers. Many of the cabins had no floors; the women, even in well-to-do families had never seen a school house and could not read or write.

With Dr. Lyman Hall, a graduate of Yale, at the helm of State, one of the first acts of the legislature was to provide for education. A bill was passed in 1784 setting aside 40,000 acres of land as a nucleus for a State University, and in the following year the University was regularly chartered.

Dr. L. B. Grandy says, "About this time there were less than two hundred medical men in Georgia, many of whom had never heard a medical lecture or seen a cadaver. Medical education consisted of an apprenticeship of a variable length of time in some doctor's office, reading his books, and helping to compound his remedies." A few of the more ambitious young men went to Philadelphia or Charleston for a course of lectures.

Smallpox ravaged the coast towns late in the 18th and early in the 19th centuries. In some places inoculation with true smallpox virus had been practiced, but this was done only on a military permit. There is no record of the date when true vaccination was introduced but it was probably early in the century, for Ramsey used it in South Carolina in 1802.

The Georgia Medical Society organized in Savannah in 1804 was the first medical organization in the State and among the first in the South. The objects of this Society, as stated in the application for charter, were "for the purpose of lessening the fatality induced by climatic and incidental causes and improving the science of medicine." There were eighteen names attached to the petition for charter, many of whom had already attained professional prominence and had rendered valuable service both professionally and as leaders in public and military life. Two of this number later

abandoned the profession, and many of them left no record of their work.

Dr. James Ewell wrote a book entitled, "Ewell's Medical Companion" which was published after he moved to Washington, D. C. The book is well written and in many respects would do credit to present day medicine. He advocated hygienic measures as a safeguard against disease; deplored the too extensive use of alcohol; built a hospital for the care of seamen sick with "bilious fever," and reported excellent results with a simple line of treatment, advised slave owners to build hospitals for their sick slaves as an economic and humane measure, because the life of one slave was worth more than the cost of the structure, besides the poor creatures could be made more comfortable. He described more than 120 different diseases and gave a splendid appendix on the preparation of home remedies. The book was not, however, well received by the profession in general.

Dr. George V. Proctor served as a surgeon in the U. S. Army during the war of 1812.

From 1790 to 1820 Yellow Fever was a disease of almost perennial interest. Dr. J. E. White, one of the incorporators of the Georgia Medical Society was more distinguished as a literary man than as a physician, and published several papers on the climatic conditions and diseases prevalent in Georgia in the Medical Repository in 1804 and 1805. He stated that the profession of that time believed in the local origin of Yellow Fever and it seems that this idea was prevalent even later than 1840.

Yellow Fever first occurred in an epidemic form at St. Mary's, Camden County, in 1808, and within 60 days had caused the death of 84 people. It did not recur as an epidemic until 1820 when Savannah was attacked in May. By the middle of December, when the last case was reported, 590 white people, one-fifth of those remaining in the City, had died. (Wm. R. Waring's official report to the City Council). As the negroes seemed to be immune, only a few had the disease.

From that time until 1878, Georgia towns and cities were visited by epidemics of more or less severity. In 1839, the foremost physician of the State, Dr. Milton Anthony of Augusta, fell a victim to its ravages.

I have been unable to find the name of any individual physician of the period who distinguished himself by original research during these epidemics, but all of them did their duty. They remained in the infected cities and attended all alike without regard to wealth or social position.

"Bilious remittent fever," described by Dr. Tomlinson Fort, was the summer scourge of the early settlers. He states that during the five years from 1808 to 1813 it caused the death of at least 25 per cent of the inhabitants of the newly opened settlements of middle Georgia, and says, "If there were no summers, there would be no bilious fever." It came on in the late Summer and early Fall and "happening as it did, all at once, gave the disease the terror of a pestilence."

"The Thomsonian Practice" was introduced into Georgia about 1818. The system appealed to the ignorant masses, because it denounced the regular practitioners, and claimed that all diseases could be cured by vegetable remedies concocted into teas and bitters. Thousands of the books were sold and people began to treat themselves, with the result that many curable diseases were allowed to progress beyond the help of the physicians. Dr. Milton Anthony is quoted as saying, "It was a disgrace to the American character." Like all such fads it has passed away.

The beginning of medical legislation in Georgia was a bill "Regulating the Licensing of Physicians" secured from the legislature by the regular profession in 1825. It provided that no one should practice medicine or surgery in the State without a license. It established a "Board of Physicians," who were to license only those found competent to practice medicine. A diploma from a medical college exempted the holder from examination. The law did much good in securing a better type of doctors.

Dr. W. C. Daniels of Savannah left us a number of valuable papers dealing with diseases and conditions of the early decades of the last century. He was first to use the weight and pulley in the treatment of fractures of the thigh and in August, 1829, reported two cases in the "American Journal



of Medical Science." Dr. Anthony of Augusta was so impressed with the method that he used it in five cases, which he reported in the "Southern Medical and Surgical Journal," October, 1836. Many years later, Dr. Buck made use of the same method in the New York Hospital, and probably owing to his better method of reporting his work, the treatment received his name.

Dr. Milton Anthony was the first surgeon to successfully operate for gangrene of the lungs. In March, 1821, he resected the fifth and sixth ribs and removed a portion of the lung tissue; the case was reported in the Philadelphia Medical Journal, Vol. VI, page 108. Perhaps the greatest work of Dr. Anthony was his efforts to better medical education. In 1827 he organized an academy of medicine in Augusta, Georgia. This was a preliminary step to higher medical education, for from the academy the Medical College of Georgia was evolved, and the first course of lectures given in 1831. A year or two later he founded "The Southern Medical and Surgical Journal," the first medical periodical published in the South. Dr. James J. Walsch in the Encyclopedia Americana said "That the origin of the American Medical Association was the results of a letter written by Dr. Anthony to the deans of all the medical colleges in the United States suggesting a 'convention of the faculties of the medical colleges of the United States for the purpose of regulating medical education, and improving the professional status of the American physicians'." Unfortunately for the medical profession of the time, Dr. Anthony was stricken with Yellow Fever and died in 1839, while he was yet a comparatively young man.

I have consumed much more space than I had intended when I undertook this task, which has been one of great pleasure; but I cannot close without quoting from Dr. Eugene Foster, who says, "Some of Georgia's noblest physicians have gone out from among the children of men and at the present time no trace of them can be found. There is no record even of the date of the birth and death of men whose lives were spent in skillful unending, unwearied toil

and self sacrifice to humanity, walking in the footsteps of the 'Healer of Genesaret'." This indeed is a sad comment upon the vanity of human life and forcibly reminds us of the oblivion which awaits the highest and noblest services of man to his fellows.

"There was the door to which I found no key;

There was the veil through which I might not see:

Some little talk, awhile, of me and thee

There was—and then no more of thee and me."

"There is no death. The stars go down

To rise upon some fairer shore;

And bright in Heaven's jeweled crown

They shine forever more."

#### BIBLIOGRAPHY

- In the preparation of this article I have consulted:  
 Garrison's "History of Medicine".  
 Encyclopedia Americana.  
 John Grimes in the Georgia Historical Quarterly, Vol. IV, No. 1.  
 Chas. N. West in Memoirs of Georgia, Vol. II, p. 244.  
 Smith, "Stories of Georgia".  
 White, "Statistics of the State of Georgia".  
 F. H. Garrison—Personal letters quoting from Appleton's "Cyclopedia of America Biographies."  
 C. E. Jones—Personal letters quoting from C. C. Jones' "History of Savannah" and "History of Augusta," Georgia.  
 White, "Historical Collections of Georgia".  
 L. B. Grandy in the Transactions of the Medical Association of Georgia, 1895.  
 Constitution and By-Laws Georgia Medical Society (Now Chatham County Medical Society).  
 R. D. Arnold's Address Jan. 1868, before the Georgia Medical Society.  
 Eugene Foster, "Memoirs of Georgia," Vol. II.  
 Tomlinson Fort, "Dissertation in the Practice of Medicine" (1849).

#### FOCAL INFECTION BELOW THE NECK\*

J. H. Butler, M.D.

Augusta, Ga.

The term focal infection does not define a clinical entity but rather describes the bacteriological, pathological and chemical vital constituents, or composition of the individual. A focus is a circumscribed region in which pathogenic micro-organisms multiply within the tissue. Recent literature has divided the subject into primary and secondary foci. By primary foci is meant the point of entrance into the human body, which is the skin and mucous membrane. In the skin, the primary foci occur where there is some break in the continuity of the skin. This is not true of

\*Read before the Richmond County Medical Society, 1925

the mucous membrane, as it has been proven beyond a reasonable doubt that the mucous membrane, though normal, may be infected. The question arises here, why do not all scratches, cuts, bruises and abrasions become primary foci? There are several reasons to be considered:

First—Is there a presence of bacterial flora at the point so injured? (This is likely.) If so, has the particular micro-organism an elective affinity for the part so injured? The duration of exposure, the duration of mechanical trauma; is the circulation at this point great or small? And what is the chemical reaction of the tissue? Cole found his investigations on the production of arthritis in rabbits by the injection of streptococci that, in certain cases, when the first injection failed to cause arthritis it was obtained when the injection was repeated. The toxic effect on the joint by the first injection localized the infection by the second injection. The above observations were repeated by Faber, who showed that a joint into which he had injected dead streptococci was sensitized, so that a subsequent injection of living streptococci into the blood stream produced arthritis into the joint into which he had previously injected the dead culture. This he found to be specific. Then came Rosenow with another conception, into the investigation of local infection: He claims to have demonstrated an elective power on the part of bacteria; bacteria which had been the cause of focal inflammation in a given tissue—namely the walls of the appendix, gall-bladder, pulp of a tooth—that these bacteria acquired a faculty of growing in these particular tissues; and if injected into animals will produce in those animals the same lesion as that from which they had been isolated. While the above report attracted much attention it has not been generally accepted.

The question, how from a primary foci do we get secondary foci? The most typical focal infections occur in cases where bacteria are conveyed by the circulation settled in definite sites in the tissue. This is brought about by the lymphatic system, and is described as the focal mechanism, not forgetting that the circulation of the blood partakes to some extent of this focal character.

The lymphatic system intercepts and destroys infection, but when the infection becomes so severe the intercepting stations become foci in which the normal mechanism is disorganized, we then deal with what is referred to by some writers as metastasis that may select any part of the anatomical structure. This then is the secondary focal infection.

At this point we must stop to consider a condition of septicemia. Lorrain Smith thinks that this condition is brought about by the formation of new blood vessels around foci that become emboli, and that they are in return taken up by the circulating blood. He further believes that the effect of the toxin recently thrown out brings about the chemical change within the circulating blood that enables the organism to grow, and that this will continue until anti-toxins are produced or the toxins become so great that death follows.

It should be noted that one disease may lead to the formation of focal lesions in a subsequent infection, as it has been noted that an individual who has suffered with rheumatism is especially liable to develop arthritis if subsequently infected by gonococci. This again brings us to the damage to the normal protective focal mechanism. Doctor Low thinks there is a definite part played by sensitization in infection. As to how many changes were due to toxin or invading organisms and how many to sensitization to the bacterial proteins, he thinks in true anaphylaxis and other forms of sensitization that evidence went to show that the fixed cells played as great a part in focal infection as the blood and the lymphatic system, claiming that the fixed cells of any tissue become sensitized to the invading organism then wherever that type of tissue cells existed if the organism was circulating it would react to that cell. That might explain why in certain focal infections only one type of tissue is infected in each case, or one kind of organism might produce different diseases according to which tissue cell was sensitized. We find this true in the skin in poison ivy, that some individuals are very susceptible while others have a natural immunity. This brings us down to individuals or hereditary tendency to focal infection.

As we well know, there are certain individuals that have a natural immunity to smallpox, typhoid and other contagious diseases. If the above is true, then will it not explain the acute and chronic types that we deal with in this day, as we see many acute infections that the foci seem to be impossible. May it not be a secondary infection following a low grade primary infection; as many times we feel that the primary foci had been removed and to our disappointment the individual does not improve.

On examining an individual for the point of foci there are a few important factors to be considered: A careful history, a study of the blood both microscopically, serologically, chemically and by culture. From the above we may draw a working conclusion. Beginning at the chest we are to consider a chronic bronchitis or bronchiectasis, para-bronchial glands, mediastinal glands and the pericardium. To refer to the symptoms that each of the above conditions would produce would be folly. Below the diaphragm we first consider the appendix, next the gall-bladder and the genito-urinary organs, last but not least the colon. From the colon we get most of our kidney and suprarenal infections.

In conclusion, the points of entrance to be considered:

First—There are such conditions as focal infections, they have to do with disease. Second—There is some chemical change within the tissue fluid that must be present before we can have a focal infection. Third—The lymphatic system and circulating blood is a source of transmission. Fourth—Some diseases are chronic, others are acute. A chronic disease predisposes to a liability of an acute condition. Then what is the answer? To be well born of healthy parents, and to guard all points of portal entrance of focal infection.

#### PRIMARY TUBERCULOSIS OF BARTHO-LIN'S GLAND

So far only three cases of primary tuberculosis of Bartholin's gland have been reported. J. W. Gordon, Detroit (*Journal A. M. A.*, June 13, 1925), adds one case. This case is reported as primary tuberculosis of Bartholin's gland because careful examination of the chest failed to reveal any other evidence of the disease.

#### METASTATIC INFECTION AS RELATED TO FOCI ABOUT THE HEAD\*

C. I. Bryans, M. D.,  
Augusta, Ga.

Although current medical literature abounds with references to focal infection, and almost every author in writing on various constitutional diseases advises a search for foci of infection as the first step in the prognosis, our present conception of focal sepsis is nevertheless a rather recent one. It is true that we find scattered references to this type of infection in the medicine of a century or more ago. Jean Louis Petit (1760), a surgeon of Paris, related his experience with dental infection and systemic disease, and after him other clinical observers made similar observations. Professor George Adami, in 1889, recognized the condition of low-grade infections and introduced the term "subinfection." He said that occasionally bacteria gain entrance to the body without there being any recognizable external lesion, and disease developing under these circumstances is spoken of as cryptogenic. He also discusses evidence favoring the view that bacteria may enter the body through certain mucous membranes.

It is the work of Frank Billings, however, which has given great impetus to studies of this group and that has led to the general acceptance of the dictum that chronic local infections may give rise to infectious metastases elsewhere, and that the removal of these areas of chronic infection may prevent subsequent recurrences of metastases and thereby relieve the patient of his disability. As Rosenow puts it: "The demonstration that streptococci in infected tonsils and teeth may have elective localizing power, placed these so-called harmless infections in the front rank of importance as hematogenous infections. Corroborative clinical evidence, indicating casual relationship between the focus of infection and systemic disease is not lacking. The foci are present in demonstrable form in a high percentage of patients with the diseases under consideration. Acute attacks often follow exacerbation."

\*Read before the Richmond County Medical Society, 1925.



tions of infections in sinuses, tonsils, and teeth. The presence of streptococci having elective affinity for the appendix has been demonstrated in the tonsils at the time of acute tonsillitis following appendicitis and their absence as recovery ensued." Rosenow has also demonstrated a similar relation in cases of ulcer, following acute infection in the tonsils and sinuses. He was likewise successful in experimental work on dogs, which leaves no doubt as to casual relationship between kidney lesions and calculi and streptococci inoculated into the teeth of the experimental animals. The kidney lesions closely resembled those of acute interstitial nephritis, which occurs often with infectious diseases. Furthermore, it was shown that dogs infected with streptococci from the urine of patients with nephrolithiasis developed calculi. The organism which was inoculated into devitalized teeth was isolated from the kidneys, from some of the stones and from the teeth of the dogs.

Foci of infection may be primary, and in this case will usually be found located in the tissues lying in direct communication with a cutaneous or mucous surface; or they may be secondary, having their origin by communication with some antecedent infection, lying either in some adjacent tissue, or so situated that pathogenic organisms can be carried from it by the blood stream or lymph channels. Among the most common origins of focal or "regional" sepsis are infections of the tonsils, both faucial and nasopharyngeal; infections originating in the teeth and jaws, especially when these conditions are such as to induce pyorrhea dentalis, or alveolar abscess, and infections of the nasal accessory sinuses. In the domain of otology the relationship of chronic foci of infections, while not so extensive, nevertheless is present in a sufficient number of conditions to warrant constant attention to this source of infection. Although we are considering focal infections as related to foci in the head only, it may not be amiss to note that chronic foci of infection in other parts of the body should by no means be neglected; such foci may exist in the bronchi, in the intestinal tract, in the urinary tract. Thus cholecystitis, appendicitis, intestinal

ulcers, salpingitis, cystitis, prostatitis, etc., may constitute foci of infection which are a menace to some hitherto healthy area of the body.

As an example of secondary foci, lymph nodes are not infrequently infected and may serve as reservoirs to retain toxins after the original source has been removed; and the constant absorption of toxins or poisons from these secondary foci often results in irritation of the kidneys, and perhaps later, chronic nephritis, gastro-intestinal disturbances, such as hyperacidity, stomach ulcer, and many other systemic conditions.

Speaking more particularly of focal infection as related to foci about the head—and by these we mean oral sepsis, dental caries, alveolar abscess and pyorrhea alveolaris, tonsil infections, suppurative sinusitis and chronic otitis media—it is not at all surprising that these conditions should be the starting point of constitutional disease or of local infections in distant regions of the body when one considers the lymphatic drainage of the nasal pharyngeal areas.

In the nasal cavities, the lymphatic tracts which originate in the accessory cavities flow together. The lymphatic reticulum of the antrum of Highmore, according to Camille Poli, is composed of a system of small canals which form large, irregular meshes, and which converge towards the ostium maxillare like the spokes of a wheel. The lymphatic vessels surround the free edge of the ostium to where they unite with those of the central nasal duct. Here they group themselves into from four to six large canals, which, frequently anastomizing with each other, take their course from the front to the back and at last reach the ridge which divides the inferior muscle from the anterior cushion of the Eustachian tube. Besides passing through the ostium maxillare, the collecting vessels also traverse the posterior fontanelle of the nasal wall of the sinus. In a few places distinct islands of lymphatic vessels, which have their origin in the periosteum are seen beneath the mucous membrane. In the cells of the ethmoid bone, an extremely fine lymphatic net is said to be found whose vessels communicate with each other by means of small canaliculi which perforate the cell-

walls. But according to Greenwald the existence of such canaliculi perforating the cell-walls cannot be demonstrated with certainty.

As concerns the frontal and sphenoidal sinuses, it may be assumed, although the proof is still lacking, that in them, too, a lymphatic network is present which connects with that of the nose. In adults the mucous membrane lining is very thin and is fitted to the rounding from the cavity walls, offering very unfavorable conditions for the demonstration of this lymphatic net. It may be concluded, however, that the lymphatic apparatus of the exterior nose, of the nasal cavities and of the nasopharynx is made up of a single net whose various parts are more or less directly connected with each other.

Studies of the lymphatics seem to prove the anatomic continuity of the whole lymph vascular system of the sinus and nasal cavities and their connection with the submaxillary retrolateral pharyngeal glands and deep cervical glands, from which the lymph drainage enters the large veins at the root of the neck. Infections of the peridental membranes and alveolar processes may likewise find their way into the general circulation through these glands.

Many authors, following the lead of pioneer investigators, have contributed reports relative to the number and variety of pathologic conditions that have originated in this way. The tonsils and teeth seem to occupy the first place as sites of focal sepsis. H. B. Anderson, of Ontario, made a careful study of the tonsils of 937 patients presenting a wide diversity of affections, laying special stress upon obtaining a history of past tonsillar trouble, as well as the more usually recorded systemic diseases, and in every case carrying out a thorough bacteriological examination of swabs from the tonsillar crypts, or the tonsils. Two hundred and sixty times streptococcus viridans was demonstrated, and it is the author's observation that this organism is especially associated with a markedly edematous inflammation rather than with the cryptic and purulent types. Hemolytic streptococci were found in 79 cases, and Anderson believes this type of organism can nearly always be demonstrated in the

throat involvement in scarlet fever, diphtheria, measles or in postnasal or sinus disease, where we have drainage into the nasopharynx. The tabulation of Anderson's cases in regard to systemic infections from which the patients suffered is very instructive. In the rheumatic group, including arthritis, lumbago, sciatica and other pains, and neuritis, there were 166 cases (27.1 per cent); the cardiovascular infections, including valvular disease, hypertension, myocardial disease and angina pectoris, numbered 115 cases (20 per cent); 100 patients (17.4 per cent) had simple goiter, while 116 (20 per cent) were suffering from gastro-intestinal affections, including appendicitis, gastric and duodenal ulcer, hyperacidity, gastric atony, cholecystitis, gallstone disease and "indigestion" of uncertain character. Diabetes and glycosuria made up 4 per cent or 20 cases, while there were 30 cases of respiratory diseases (bronchitis, asthma and pleurisy) representing 5.4 per cent. More than half the patients were found to have oral sepsis and "healthy tonsils are rarely, if ever, found, where the mouth is seriously infected." A series of cases of this kind demonstrates in a striking manner the widespread relation between general medical disease and focal infection which physicians encounter in the routine of general practice.

Equally, if not more important, is the connection which can be readily established between systemic conditions and septic conditions originating in the mouth and gums. I do not believe there is a greater menace to health today than crowned and bridged teeth, to say nothing of imperfectly filled and dead teeth, and of pyorrhea alveolaris, though we might qualify this by adding that infection of the tonsils and sinuses adjacent to the nose must never be overlooked. We do not know how many pneumonias following or accompanying influenzal affections, occur because pneumococci are being carried in the mouth. We do not know how many times irregularity, weakness and actual disease of the heart are due to germs harbored in the mouth. Neither do we know how frequently streptococcus viridans is the cause of heart disease, or adds its fatal potency to an already established chronic disease.



Lester R. Cahn classifies infected processes in the mouth into conditions affecting the gums and peridental membrane, such as the various forms of stomatitis and pyorrhea alveolaris, and infective processes occurring around the apices of the teeth, or apical infections. Of the diseases of the gums and peridental membrane, pyorrhea alveolaris is by far the most insidious and dangerous. Its cause is not understood; yet we know that trauma in the form of ill-fitting fillings, tartar, clasps and other mechanical devices plays an important part in the etiology of this condition. Malocclusion of the teeth, infective organisms and systemic involvements are other etiologic factors. Apical affections are of both acute and chronic varieties. They are caused by infection through the root canal. In the acute variety we have all the symptoms of acute inflammation—pain, redness, swelling. This type of apical infection is the less insidious of the two, because there is fair warning that some abnormal process is going on, but the chronic form is more dangerous. This type of inflammation is of the productive variety. Due to toxic irritation, the peridental membrane proliferates, causing a dental granuloma, a chronic dento-alveolar abscess, which may harbor the streptococcus viridans, streptococcus haemolyticus or other varieties of pathogenic micro-organisms. Cahn goes on to say that systemically oral sepsis causes many obscure conditions, such as arthritis, myositis, infective endocarditis and toxic neuralgias.

Fortunately, a dental abscess always produces symptoms due to absorption of poisons before any direct germ extension takes place. Two persons are seldom affected in exactly the same way. Some of the subjects often have high blood pressure with a tendency to arterio-sclerosis, while others have some of the different lesions and symptoms called rheumatism. Again, others have neuritis, neuralgia, and various eye troubles. Some authorities, among them the Mayo Brothers, go so far as to claim that ulcer and cancer of the stomach, and cancer of the gall-bladder are due to dental infection.

In connection with focal infection as related to the accessory sinus McClary makes

the statement that 75 per cent of maxillary antrum infections have their origin in diseased teeth; that if careful examination be made the apices of one or more teeth will be found to project into the antrum, in consequence of which abscess of such a tooth may easily infect the antrum. Following such an infection any number of complications may follow, such as iritis, optic neuritis, perineuritis, cellulitis of the orbit, osteoperiostitis of the floor of the orbit and sometimes thrombophlebitis. Hamill describes disease of these sinuses as "merely a focal infection in a cavity which, because of the swelling of the lining membrane, can become a place where pus is under increased pressure, a place from which septicemic or pyemic—these terms are used in their broadest sense—involvement of the rest of the body may occur." A sinus makes an excellent culture tube, and it can be seen how readily the sinuses lend themselves to secondary infections from the teeth or tonsils. The teeth, tonsils and sinuses should be classed under one head, inasmuch as they have a common bacteriology and symptomatology and cause common systemic disorders. Every physical examination should include all of these as being but parts of a single disease." J. A. Stucky, in discussing the part played by the sinus writes: "By far the most frequent, misleading and unyielding condition met with by the practitioner and neurologist, in which the foci of infection is to be found in the accessory sinuses, is *headache*. Nasal and accessory sinus disease in its relation to headache is of peculiar interest because of comparatively recent discoveries in this field of observation. The headache of frontal sinus congestion and empyema is intense and almost unbearable, and is worse in the morning hours, is aggravated by stooping or any exercise which jars the body. The inner angle of the orbit is sensitive to pressure and mental activities are diminished." Volumes could be written along this line, and Sluder has recently written a book on headache of nasal origin.

That infections of the nasal cavities are often responsible for eye affections is well known, and while time forbids us to go into



detail with reference to this phase of focal infection it is interesting to note, however, that the eye in several respects offers advantages for the study of chronic metastatic infection greater than those presented by the joints, and studies of the causes of iritis lead us to the conclusion that in most cases these are associated infectious processes demonstrable by careful examination, and in a very large proportion the removal of these infections frees the patient from recurrences.

Up to recent years it has generally been held that syphilis was responsible for 50 to 80 per cent of cases of iritis, and the remainder was regarded as "rheumatic" or "toxic" for lack of better terms, but Irons, in association with his colleagues, studied 200 cases of iritis and found syphilis as a cause in less than 25 per cent. With the recognition of chronic iritis as a factor in metastatic infections many cases of arthritis have been relieved, and the patient with iritis no longer wanders from oculist to oculist, regarded by each as an unwelcome guest, or as a certain candidate for intensive antiluetic treatment. A number of authors have called attention to infection of the nasal accessory sinuses as a cause of optic neuritis, but time forbids that we should discuss this result of focal infection.

The relation of focal infection to the ear, while it has not been written of to the same extent as that in other organs, is none the less real. We are aware of the fact that a chronic suppurating ear is in many instances kept in this chronic state by infected tonsils and adenoids or infected accessory sinuses. Only by thorough eradication of these foci of infection can we in any measure hope to control the discharge from the ear. Then, again, a chronic suppurating ear may be the cause of a metastatic purulent panophthalmitis, necessitating the enucleation of the eye, and in our studies in neuro-otology we often find an irritative or toxic labyrinthitis due to chronic foci of infection elsewhere.

In a review of the literature on the treatment of foci of infection, authorities are in unanimous accord that the only rational course is elimination of the source of infection, whether this consists in the ablation of

tonsils, the removal of teeth and curettage of alveolar pockets, the opening and drainage of nasal sinuses or the effective clearing up of a chronic otitis media, or of any other nidus that is harboring pyogenic organisms. At the same time we should take conservative measures toward the elimination of evident infection by attention to maintenance of nutrition and the suitable and individualized orthopedic and other measures which will raise the individual's resistance, as this will result in the limitation of the progress of the disease and improvement in a larger proportion of cases than has hitherto been thought possible. In connection with failures to effect a cure by surgical removal of foci of infection it must always be remembered that even when the infective focus has been found and removed, the evil effects of the toxins it has generated are by no means invariably eradicated with it and furthermore we must not forget the possibility that the focus which has been removed may not be the only one that is flooding the system with its poisonous products. On the contrary, each infected gland, joint, ear or eye, as the case may be, becomes a focus of itself and so continues after the primary focus has been removed.

Although we have been able in a short paper of this kind merely to skim the surface of the subject of focal infection, which has become so broad that it has become a part of every branch of medicine, we shall feel satisfied if we have succeeded in emphasizing the need of searching for the cause of any obscure internal condition and that we are guilty of negligence if we fail to make a very thorough examination of all those parts where focal infections are liable to be situated.

#### FACIAL PALSY FOLLOWING SCARLET FEVER

Two cases of unilateral peripheral facial palsy are reported by P. N. Mutschmann, Calumet, Iowa (Journal A. M. A., May 30, 1925). Both cases followed attacks of scarlet fever, with apparently only a moderate degree of glandular involvement, and both, after several months of apparently complete clinical recovery, have developed an intermittent paralysis of the seventh nerve on the right side.

**ANENCEPHALIC MONSTER****Case Report**

**O. R. Thompson, M.D.**  
**Macon, Ga.**

According to the leading authorities, an anencephalic monster is an abnormally developed fetus, classified as a monster, possessing a trunk, but only an imperfectly developed head, from which a large part of the brain and skull is lacking. Ordinarily such beings are of moderate size, but occasionally the shoulders may be so excessively developed as to give rise to serious dystocia.

Owing to the absence of the cranial vault, the face is very prominent and somewhat extended, the eyes often protrude from their sockets, not unlike those of a frog, and the tongue hangs from the mouth. The brain is in a rudimentary condition, and the base of the skull is accessible to the examining finger, so that the sella turcica can be distinguished. Owing to the exposed condition of the base of the brain and the upper part of the medulla, there is commonly a marked increase in the amount of the amniotic fluid.

In reviewing the literature we find that Bagg explains certain congenital structural defects as the result of arrested development, resulting from local blood vascular extravasation, but does not offer a plausible explanation for such blood vascular lesions occurring during uterine life. Stockard has produced twins, double monsters and deformities in fish by reducing the oxygen supply to the eggs at a crucial time in their development. In view of this work, Talbot holds that it is more probable that the injury to the placenta and the placental site, caused by the beginning infarct, reduces the total area for oxygen interchange between the mother's blood and the fetal blood, and assumes that such an injury will cause a temporary cyanosis in the embryo. Should the accident occur at the time when some part of the embryo is undergoing rapid proliferation or budding, such a part will be inhibited in its growth, resulting in failure or abnormal development.

Talbot believes that the placental infarct is the result of hematogenous infection of the maternal blood vessels of the placental site. The primary lesion is hemorrhagic in nature; the white infarct is secondary.



**Fig. 1. Anencephalic Monster, 8 months**

We know the embryo within the first forty days of its development consists in a series of bundles of cells, each bundle having the power of further differentiation into several parts of the body. Injury to any one of these bundles would result in a lack of development of that part, with distortion of contiguous parts. A subplacental hemorrhage, the first stage in the formation of the white infarct, or any disturbance of the placental circulation during the first weeks of gestation, would without a doubt produce a temporary cyanosis of the embryo, resulting in arrested differentiation and budding of the cell mass, at that time undergoing rapid development. Upon this Talbot bases his theory and reports twenty consecutive cases of deformed babies which show evidence of placental damage near the base of the cord.

The etiologic factor in the production of the placental damage is claimed by Talbot to be some acute infection or chronic sepsis. In the cases reported by him all but one gave a history of having had a severe cold in the head, bleeding spells, or of having been associated with foci of chronic infection.

Mall points out that full 50 per cent of abortions contain malformed embryos, and that twelve monsters abort to every one that goes to full term.



Fig. II. X-ray showing absence of cranial vault in Anencephalic Monster

#### Case report:

L. G., colored female, age 28, para iv, applied to the out-patient obstetrical service on April 30, '24, for observation during her pregnancy.

Last menstruation Dec. 25, '23, expected confinement Oct. 1, '24.

Family, medical and menstrual histories negative.

Previous pregnancies normal.

Toxemia, none.

Previous labors, short.

Present pregnancy, no complications to date.

General physical examination, negative. B. P. 130-60. Wassermann negative.

Pelvimetry: H. F. 15; Sp. 1.23; Cr. 1.24; R. Ob. 21; L. Ob. 21; E. C. 20; C. D. 11.5; C. V. 9.5; A. P. 10.5.

The patient did not return to the clinic for further observation and was seen the second time at her home Aug. 28th, following an urgent call from a midwife.

When asked about her general condition before the onset of labor the patient said that she was as "big as two women," had not had any headache, and that her feet had not been swollen.

Labor History: Pains began 8 P. M., Tues-

day, Aug. 26th, were slow and nagging in character, lasting throughout the night and the next day. The membrane ruptured about 7 P. M. of the 27th. From the description given by both the patient and the midwife there must have been a tremendous amount of amniotic fluid. The pains grew harder, and more frequent, and delivery was effected about midnight of the 27th.

The first part of the baby to come into view was the undeveloped brain. The midwife became frightened and thought that she had "skint" the baby. There was apparently no dystocia. The baby did not show any signs of life, and after it was delivered there was again a great amount of amniotic fluid to escape.

After waiting a few minutes the placenta and membranes were delivered intact. The hemorrhage following the delivery of the placenta was apparently normal.

The placenta had been destroyed. I regret very much not being able to make a careful study of the placenta. According to Talbot's theory I probably would have found a white infarct at the base of the cord or a battledore type of placenta.

Gross description of the apparently 8 months fetus:



Baby G., female, wt. 1500 gm., length 38.5 cm., greatest diameter head, immediately above the ears 6 cm., length of head and neck combined 5.5 cm., diameter of head, chin to posterior head mass 6 cm., Acromion diameter 11.5 cm.

Apparently normal 8 months fetus except the cephalic condition. Eyes have the appearance of those of a frog, mouth open and tongue protruding. The skull shows development in the mastoid region, extending forward to the parietal region to a point just above the eyes, and in the back extending posteriorly from the mastoid regions joining in the mid-line just below the place normally occupied by the occipital protuberance. There are ridges extending from the posterior part of the mastoid masses, running forward toward the mid-line, which are apparently representing the petrous portion of the temporal bone. The region normally occupied by the hind-brain presents a cavity covered by a thin membrane. In the center of this membrane there is a small hole about the size of a match head from which exudes a serous fluid. This membrane passes forward over the temporal region, covering a small mass in each temporal fossa. The space normally occupied by the fore-brain is covered by a continuation of the previously mentioned membrane, and has beneath it a mass of tissue presenting an attempt at convolution formation. This mass extends forward between the eyes. From outward appearance there is no abnormality of the spine. Umbilicus normal, anus and vulva well formed, and the extremities normal and well developed.

#### X-ray findings:

Upper extremity: Reveals a normally developed thorax, extremity and spine. Skull: Anteriorly there is a normal development of the face, malar bones, and the portion of those bones forming the orbit. Immediately above the super-ciliary ridge there is a thinning of the frontal bones and complete absence at the point where the frontal eminence should be. Laterally there is mal-development of the sphenoids on a plane with the articular surface of the frontal process of the malar bone. Extending backward there is no development of the wing of the sphenoid nor

temporal bones above a plane extending from the above mentioned process to the occipital protuberance of the occipital bone. There is no brain formation above this plane except an attempt at convolution of the fore-brain. The hind-brain is not noted.

#### Conclusion

The causative factor in the production of mal-formed embryos, and especially such gross deformities as anencephaly, is at the present unknown. Of all the theories advanced, Talbot's seems the more plausible. He is probably thinking along the right line but hasn't the right to draw a definite conclusion from only twenty cases.

#### REFERENCES

- Talbot, J. E.: *Jour. Obst. & Gyn.*, Sept., 1924, pp. 271-288.  
 Bagg, H. J.: *Jour. Obst. & Gyn.*, Aug., 1924, pp. 131-141.  
 Williams, J. W.: *Obstetrics*  
 De Lee: *Principles to Practice of Obstetrics*.

### THE RELATION OF PREVENTIVE PEDIATRICS TO EPILEPSY\*

G. W. Holmes Cheney, M. D.,  
Atlanta, Ga.

In presenting this paper, the predominating idea is the study of the premonitory symptoms of epilepsy in childhood; the underlying etiological factors; and the early removal or amelioration of these.

Block in his worthy contribution on Epilepsy, Tice's Practice of Medicine, states: "Anybody who is looking for one cause of Epilepsy might as well stop looking. Epilepsy is a symptom of many disorders,—organic, physiological and chemical. It seems evident that Epilepsy is not due to one cause, but to a combination of causes, which are necessary to produce the attacks." Therefore, for the purpose of this paper it may be well to make a broad classification of the disease into "Symptomatic" and "Idiopathic" Epilepsy; including under the first division all those cases of known etiology. At one time, do we not know, that the greater percentage of cases fell under the "Idiopathic" group. As progress has been made and the recognition and proper emphasis placed on foci of infection, endocrin disfunction, syphilis, false metabolism, and other pathological physiology, do we not know that the percentage of cases placed in the symptomatic group is now in the

\*Read before the Pediatric Section, Fulton County Medical Society, April 9, 1925.

majority and ever increasing. Our effort in the future as Pediatricians, working along the lines of prevention, should be to study the childhood manifestations of this malady and prevent the establishment within the nervous system of the epileptic state.

Among the etiological factors in childhood may be mentioned the following:

Congenital neuropathy; foci of infection,—infection and contagion; endocrin disorders; syphilis; metabolic disturbances; cerebral focal lesions and worms.

Congenital neuropathy is of outstanding importance. Michael (1) states that about one-third of the progeny of those whose family history is positive, develop epilepsy in some form. He states further that marriage among those with such a history, should be discouraged. It behooves us to study the family history in every case coming under our observation and to watch most carefully those patients with a positive history, even though we may note no early evidence of this disorder; bearing in mind that thirty-three and one-third per cent of these patients may develop the characteristic symptoms at a later date. Certainly those cases who show degrees of ego-centricity, emotional poverty and hypersensitiveness, along with the early evidence of the inability to make fundamental life adaptations and adjustments, should have our utmost care and attention. Given the above neuropathy, and add to it an infection, toxemia, endocrin disorder or any of the etiological factors and the chances for a classical case are good. No other class of patients try the soul of the pediatrician more; none require keener insight and intuitive response. Here a real influence over the parents of the child is of importance, for it may be necessary to alter the general familial perspective in order to give the patient the greatest aid in overcoming this congenital deficiency.

Endocrin disorders are of the greatest importance as a cause in epilepsy. Although the literature is already voluminous, yet from the standpoint of diagnosis and therapy in epileptic or pre-epileptic cases, this is an almost virgin field. Empiricism runs rampant and this is distasteful to the scientific worker, yet it is a mooring place, at any

rate, for our craft on a more or less "uncharted sea." Evidence of real progress in the treatment of epilepsies, showing symptoms of endocrin imbalance is of record. Leahy (2) in his paper on "Epileptiform Manifestations in Endocrin Disorders," reports cases whose symptoms clearly point to an endocrin disfunction. Likewise Joughin (3) and Tucker (4), (5), the later reporting twenty-seven cases, all showing an hypophyseal imbalance. Tucker states that a condition of the pituitary gland causing a change in its secretion must be placed as a cause of epilepsy. Among the symptoms noted were,—diminished perspiration, lessened sexual development, bradycardia and lowered blood pressure; mental sluggishness and muscular asthenia. His therapy included, essentially, the administration orally of the dried whole pituitary gland and the anterior lobe. In all of his cases the general health and mental condition along with the convulsive seizures, improved or were relieved completely, except two cases. In one case the attacks were cut down to three in two years, instead of one a month. The second case, one slight attack in two years instead of two to four a week, and this one seizure occurred when medication was stopped for a period. Lissner (6) also finds the pituitary gland at fault. Lowenstein (7) reports sixteen cases of epilepsy and states that certain cases are apparently benefitted by pituitary gland administration. In this series thirty-one per cent were improved. The idea to be stressed in this paper, however, is the importance of the early recognition and treatment of these cases before a definite epileptic state has been established.

Congenital syphilis plays no minor role in the drama of epilepsy. Every case should not only have a blood Wassermann, but also a spinal fluid Wassermann, along with a Colloidal Gold Test.

Metabolic disturbance may manifest itself through epileptic seizures. The vascular system may be a constant carrier of toxic products of false metabolism. Ozenato (8) in his paper states that from reliable data the vascular system, as a carrier of toxic products, may be the offending element. He

quotes Cuneo, who named the proteoses as convulsive producing substances and showed that when painted over the motor cortex, they are capable of producing epileptiform attacks. Cuneo was able to produce typical epileptiform seizures in dogs by the intravenous injection of proteose, derived from nucleo-proteins. He believes that an albumosemia exists in epilepsy. Be this as it may, diet regulation should be enforced, and the products of its metabolism studied at every stage, in neuropathic cases. Gastric and duodenal analysis along with a careful study of blood, urine, and feces, may be of vital importance in solving the problem.

Helminthiasis or worms was included among the etiological factors of epilepsy. While there has been no definite proof, yet the reports of Block (9), (10); Peiper (11) and Loos (12) and others would cause us to study this phase of the malady, especially from the standpoint of prevention. Block reports two hundred cases. In thirty-seven of these cases worms or ova were found in the stools. Of these two were taenia, thirteen ascaris, seventeen hookworm and three oxyuris. From Block's private cases, he reported a series of one hundred. Twenty-one showed ascaris; seventeen hookworm; four oxyuris; one taenia nana; one taenia saginata. From this series forty-four per cent had worms. How may they cause the convulsive seizures? To quote further from Block, he mentions:

"Reflexly; toxins and cerebral invasion with cyst formation."

Peiper regards the nervous symptoms from ascaris infection, not as a reflex, but from toxin in the helminth producing a false metabolism.

Block states that the actual invasion of the brain by the larvae of worms finds its greatest support in the cases with cyst formation. The well known tendency of hookworm to invade most of the organs of the body leaves little doubt that they also reach the brain. Loos has shown experimentally that the larvae enter the skin and are found in the veins, arteries, and lymphatics through which they pass to the heart and lungs. Block goes on to state that there is no reason why they should not reach the brain. We

would therefore state that in all neuropathic children a helminthiasis should be repeatedly sought for and eradicated if found.

The inspiration of this paper came from five cases, coming under our care during the last two years; together with the good improvement in these patients following careful study and treatment. (Only the positive and significant findings will be given.)

Case No. 1. B. D.; male; white; age eight years. Admitted April 4, 1923.

Complaint: Nervous spells.

Family History: Negative.

Past History: At four and one-half years of age patient had a severe attack of measles. His temperature was very high and protracted, with evidence of an excessive toxemia. The illness was complicated by a double otitis media. During the convalescent period patient became very nervous, and at various times during day and night would have nervous spells. His face would become blue, eyes cross, tongue protrude in and out rapidly. There was loss of consciousness and passage of urine. Following his recovery from measles, patient continued to have convulsive attacks; sometimes, several daily and during night. Following attack he would go into stupor and sleep for several hours.

Habits: Masturbation.

Present Illness: Began with seizures noted above and have continued; at times they are milder and then again worse. Patient has not developed mentally or physically as he should, and although eight years of age cannot go to school.

Physical Examination: Weight 45½ pounds, height 3 feet 8¾ inches. Appears anemic, undersize and very nervous. In the act of carrying out a task, will suddenly stop, stare into space and become cyanotic. Knees will weaken and body sag, with loss of consciousness and passage of urine at times. The attack may pass off and patient resume his occupation. Mentally and physically the boy is about six years of age.

Eyes: Pupils dilated, reacting to light and accommodation. Retinal vessels tortuous and very much congested during attack.

Mouth and Throat: Teeth are very carious and in poor state of preservation. Gums are



much inflamed, with pus and bloody exudate along edges. Two abscesses noted in gums, localized. Tonsils are hypertrophied to excess with marked congestion and many sinuses exuding pus. Tonsils almost meet in midline.

Nose: Upon digital examination adenoid growth is profuse, practically blocking posterior nares. The turbinates are congested.

Lungs: Rapid respiratory rate.

Heart: Accelerated with occasional extra systoles.

G. U.: Repeated erection of penis.

Reflexes: Exaggerated.

Urine: High indican.

Treatment: Corrected hygiene, rest and a well balanced diet instituted. Abscesses in gums drained. Carious teeth filled and extracted, as indicated. Tonsils and adenoids removed.

Medication: B. & W. Mixed Glands. Local applications to throat, nose and gums.

Progress Notes: May 8th, or one month after treatment began: Weight 45½ pounds, appetite improved. Mother feels that patient is more normal. Attacks are not so frequent nor so protracted.

July 16th: Weight 45½ pounds, height 3 feet 10 inches. Attacks have ceased. Patient is still very nervous. Mentally clearer, and disposition improved. Growth 1¼ inches. Pyorrhea improved with no apparent purulent exudate or bleeding. Habits improved.

December 8th: Weight 49½ pounds, height 3 feet 11 inches. No attacks; condition much improved.

February 1, 1925: Weight, 56 pounds, height 4 feet 2¼ inches. Net gain in weight 10½ pounds. Net increase in height 5½ inches. No attacks. In second grade at school. The last attack was twenty-two months ago.

Case No. 2. F. A., Jr., male; white; age on admission 3 years. Admitted May 6, 1924, complaining of convulsions.

Family History: Four children. Patient is only member of family afflicted.

Past History: Positive history begins at two years of age, when patient had first seizure. Mother describes as coming on suddenly, with patient falling, losing conscious-

ness, facial twitchings, rolling eyes, with jerking movements of arms and legs; face very blue at beginning of attack. During attack, urine or feces sometimes passed. Following convulsion child would go into deep sleep for several hours. At first seizures were at monthly intervals but increased after some months to one each week and finally to as many as seven in twenty-four hours. There is no history of illness prior to beginning of attacks.

Diet: From birth until two years of age, patient had been fed on Eagle Brand Condensed Milk.

There is positive history of mouth breathing, with repeated attacks of tonsillitis.

Present Illness: Attacks as above noted have increased in severity and number.

Physical Examination: Weight 26 pounds, 7½ ounces; height 3 feet.

Small child for age but development is symmetrical. He is 25 per cent under weight for age, and 11 per cent under weight for height.

Nose and Throat: Posterior pharynx presents profuse growth of adenoids. Tonsils are hypertrophied, bilobed and necrotic.

Reflexes: Markedly exaggerated.

G. U.: Long adherent prepuce, with pronounced bulging back of corona.

Treatment: On May 10, 1924, adenoids and tonsils were removed. Circumcision was done at this time. In removing right tonsil, while milking tonsil through fenestra of instrument, tonsil collapsed with profuse flow of thick yellow-green purulent material. There were dense adhesions of prepuce to glans penis, and posterior to corona a profuse collection of foul smelling smegma material was removed. Following operation patient's convalescence was uneventful. There were no convulsive seizures.

July 17th: There have been no convulsions to date; general condition of patient much improved.

February 19, 1925: Weight 28 pounds 6¼ ounces; height, 38 inches. Age 4 years.

Patient appears much improved. Reflexes not exaggerated. There have been no attacks. The last convulsion was 12 months ago.

Case No. 3. L. M. Age 10 years. Fe-

male. Admitted on September 14, 1924, complaining of "fits."

Family History: Father has had similar attacks.

Past History: Patient had first attack at about three years of age, and at one to two month intervals. As child grew older seizures became more frequent. She knows when attacks are coming on; becomes pale; cries out and falls, losing consciousness. Her head is usually drawn to right side. Following the spell, patient goes into profound sleep from which she is difficult to arouse. At times several attacks follow in succession.

Physical Examination: Malnourished girl; very nervous.

Eyes: Pupils dilated and react sluggishly to light. Retinal vessels are very tortuous.

Reflexes: Exaggerated.

Serological: Blood count reveals 13,400 white cells, with a lymphocytosis.

Blood Wassermann: Negative.

Spinal Fluid Wassermann: Second specimen, weakly positive.

Colloidal Gold Curve: 0112310012, or Luetic Curve.

Treatment: Several doses of salvarsan (.3 mg.) were given at weekly intervals, intraspinally. Patient improved; she had a slight attack, after first treatment. There is no further record of this case, as family moved from the city without giving address.

Case No. 4. J. C. Female, 9 years; admitted December 1, 1924, complaining of epileptic fits.

Family History: Mother states that she has spells about once each week, and has had them for years.

Past History: At three years of age patient had first attack. She became very pale, and ran to mother. Her eyes rolled back, arms jerked and she lost consciousness. These spells came at intervals of about two months.

Present Illness: About one year ago condition grew worse, with more frequent seizures. Recently patient has had as many as three in one day. At times during attack urine is passed without control.

Physical Examination: Fairly well nourished girl, appears nervous and anemic.

Nose and Throat: Profuse growth of ade-

noids. Tonsils almost meet in midline; breath very foul.

Reflexes: Exaggerated.

Skin: Dry and scaly.

Hair: Thin and dry.

Treatment: (B. & W.) Mixed Glands No. 2, one tablet three times daily. One quart of milk daily. Two hours rest in afternoon. Tonsils and adenoids removed December 28, 1924.

On December 30th, patient had severe attack. Since this date, however, there have been no further seizures.

Case No. 5. M. L. Age 3 years; female; admitted February 27, 1925, complaining of "Convulsions."

Past History: First attack about one year ago, followed by one or two each month. Patient runs to nearest person, requesting that she be held; she cries out and loses consciousness for several minutes. Sleep follows the attack.

Present Illness: Attacks have increased to one or two each week.

Physical Examination: Well nourished girl. Weight 26½ pounds. The fat distribution is irregular, being paddy in posterior neck, thyroid and dorsum of foot areas. Skin and hair very dry.

Reflexes: Very sluggish.

Mentally: Sluggish.

Treatment: Diet regulation. Thyroid Extract grs. 1-10th, B. I. D. increased to grs. 1-5th, T. I. D.

On April 6th patient weighed 28¼ pounds. No convulsions since March 1st.

#### BIBLIOGRAPHY

- (1) Michael, J. C.: Epilepsy as a Curable Disease. *Jour. Lancet*, Minneapolis; 1923—XLIII, 349.
- (2) Leahy, S. R.: Epileptiform Manifestations in Endocrin Disorders. *N. Y. State Medical Journal*; 1922—XXII, No. 1, 8-14.
- (3) Joughin, James L.: The Epileptic Syndrome and Glandular Therapy. *N. Y. Med. Jour.*; 1916—civ 693.
- (4) Tucker, Beverly: Hyperpituitarism in its Relation to Epilepsy. *Va. Med. Semi-monthly*; 1916—XXI, No. 1, p. 1.
- (5) Tucker, Beverly: The Role of the Pituitary Gland in Epilepsy. *Archives of Neurology and Psychiatry*; 1919—LI, 192.
- (6) Lissner, H. and Nixon, C. E.: Dyspituitarism and Epilepsy. *Med. Clinics of North America*; 1923—VI, 1471.
- (7) Lowenstein, Paul S.: The Relation of the Pituitary Gland to Epilepsy.
- (8) Ozenato, M.: Critical Review with a New Interpretation of the Available Data. *The Archives of Neurology and Psychiatry*; April, 1923—No. 4, p. 488.
- (9) Block, E. B.: The Etiological Relation of Worms to Epilepsy. *Jour. Med. Assn. of Ga.*; 1921—X, 309.
- (10) Block, E. B.: The Etiology of Epilepsy. *Jour. Southern Med. Assn.*; 1920—XIII, 469.
- (11) Peiper: See Fantham, p. 649. Vide Seifert Lohrb. d. Kinderkrankh; 1897—243.
- (12) Loos: Records of the Egyptian Government School of Medicine; 1911—IV.

# THE JOURNAL

OF THE  
MEDICAL ASSOCIATION OF GEORGIA  
Devoted to the Welfare of the Medical Profession of Georgia.

65 Forrest Ave., Atlanta, Ga.

JULY, 1925

ALLEN H. BUNCE, M. D., Editor

Publication Committee

CHAS. USHER, M. D.

S. J. LEWIS, M. D.

T. C. THOMPSON, M. D.

Articles are accepted for publication on condition that they are contributed solely to this Journal.

Manuscripts should be typewritten, double-spaced, and the original (not the carbon copy) submitted. Used manuscript is not returned unless requested.

Communications and items of general interest to the profession are invited from all parts of the State. We especially invite county society secretaries to send us information of happenings in the county that would be of interest to the members throughout the State.

## Editorial Department

### A MESSAGE FROM THE PRESIDENT

To the Medical Association of Georgia:

The administration of 1924-25, under the active guidance of President Elrod, Secretary Bunce, and their staff, leaves the Association in a most gratifying condition. Of the 162 counties in Georgia, which is the largest number of any state in the Union except Texas, 104 counties have medical societies, an increase of 1 over the preceding year. The total membership of the Association is 1,537, which is 116 more than the preceding year.

Most of the county societies are holding regular meetings which are fairly well attended and which present attractive and instructive scientific programs. The character of work being done by the average member of the Association has improved materially during the past quarter of a century. Due to better preparation in college, easier access to the gatherings of medical men, and the establishment of hospitals and laboratories in all sections, the so-called country doctor has about the same advantages as his city brother.

One of the main functions of any medical organization is the dissemination of scientific knowledge among its members. If a society tries to do anything, it will do this, so we are

not particularly concerned about a paucity of good papers and discussions in our meetings, although there is always room for improvement. Neither does it appear that there is a marked want of professional fellowship in our midst. Jealousies and ill-feeling, usually engendered by misunderstandings or by lack of personal acquaintanceship, will always exist among certain individuals, but by and large we are a harmonious and fair-dealing body of men.

But we must not allow self-satisfaction to blind us to the tasks which lie before us. More exists in the purpose of medical organization than the mere holding of meetings. A commencement speaker recently has said that the chief aim of an education is not to equip us to help ourselves, but to help others. The medical profession is an educated group of men who always have put service above self, and new calls for service are sounded constantly and must be answered.

The objects of the present administration will be not only to increase the number of county societies and stimulate more interest in them, add to the membership and urge the payment of back dues, but more than this to advance the cause of public health and preventive medicine. By public meetings and proper press publicity already much is being done to spread the right sort of information among the people. Sometimes our efforts in this direction are discouraging, but persistent activity is bound to accomplish good results. The importance of detecting disease in its incipency, or of altogether forestalling it, only lately has been called to the attention of the people. Any county society will blossom with new life by putting on a vigorous campaign to show its citizens the value of periodic health examinations.

Two paramount propositions now face the majority of the membership of the Medical Association of Georgia, first, the reporting of notifiable diseases, and second, the inauguration of the Ellis Health Law in every county. The Board of Health, so crippled by lack of funds, is further handicapped by our failure to co-operate in these matters. By neglecting to report these diseases we damage the good name of our state which already has fallen



from its prond place as the Empire State of the South. Three striking examples are snficient to explain the absurdly high mortality rate with which we are credited in Washington by our carelessness. Dnring the year 1924, 1,151 cases of pnemmonia were reported from Georgia, with 2,161 deaths; 652 eases of pulmonary tuberculosis were reported, with 2,620 deaths; 601 cases of typhoid fever were reported, with 671 deaths. Such statistics as these should be ample plea to compel every member of the Association to do his duty in reporting the notifiable diseases.

The necessity for a working Ellis Health Law in every county has been emphasized so often as no doubt to become tiresome, and yet of the 162 counties only 20 are operating under it. Fourteen other counties have adopted the law, but it is not in force, while three other counties have full-time health departments, but are not under the Ellis law. What a stimulus it would be to those county soeities where this admirable provision is not in effect to determine this year to make it so, and what a Godsend it would be for the people of these counties! The Bureau of Vital Statistics tells us that in this state during the past five years there were 347,000 eases of preventable diseases (smallpox, measles, whooping-cough, diphtheria, malaria, typhoid, tuberculosis, etc.), with 34,740 deaths.

A properly conducted health department in every county would soon cut down such staggering figures as these. No feature of county government can be of more importance than its health department, and no county medical society can render greater service to its community than to see to it that the county is given the best health protection possible. A society which vivifies itself by carrying out such an object will have no dull meetings.

Finally: Perhaps the magnetic state of Florida needs more money for health work than Georgia, but Florida is giving twenty-five cents per capita to its Board of Health, while Georgia is starving the work of its board with three cents. Georgia has the finest climate in the world, but the difference is not this great. The legislature is being

asked this summer to increase the amount appropriated to six eents per capita. Every member of the Medical Association and every voter should urge their representatives to support this absolutely necessary increase.

I hope during the year to have the pleasure of meeting a large proportion of the doctors who compose the Association. I shall attend every county and district meeting possible. Let us all join hands to put into effect a program of health conservation in Georgia which will be a mighty step forward in restoring our state to its former position of leadership.

FRANK K. BOLAND.

### ZINC STEARATE DUSTING POWDERS FOR INFANTS

The second report of the Committee on Accidents from Zinc Stearate Dusting Powders appointed by the Board of Trustees of the American Medical Association has recently been published. Copies of this report, with an appendix showing the opinions of thirty-four representative pediatricians on the therapeutic value of such powders, can be obtained on request. Address, Committee on Zinc Stearate Dusting Powders, American Medical Association, 535 North Dearborn St., Chicago, Ill., enclosing a self-addressed, stamped envelope.

There were reported to the Committee 131 accidents from the inspiration of zine stearate dusting powders by infants. Twenty-eight of the victims died. The Committee conferred with representatives of certain distributors concerning the dangers incident to the use of such powders on infants. Following a meeting held at the headquarters of the American Medical Association, these distributors agreed to co-operate by adopting self-enclosing containers for the powders they distribute and agreed that cautionary labels are desirable. Opinions were secured from thirty-four representative pediatricians concerning the therapeutic value of zine stearate dusting powders. Thirty-one believe that such powders have no advantage over other dusting powders, that they constitute a hazard to infant life, and that their use should be discouraged.

## District and County Societies

The Secretary of each county society shall report to the Journal of the Medical Association of Georgia full minutes of each meeting and forward to it all scientific

papers and discussions which the society shall consider worthy of publication.—Constitution and By-Laws, Chap. VII, Sec. 15.

1. Demmond, E. Carson, Savannah.
2. Wood, A. W., Albany.
3. Greer, Chas. A., Oglethorpe.
4. Blackmar, Francis B., Columbus.
5. Fitts, Jno. B., Atlanta.
6. Hawkins, T. L., Griffin.

7. McCord, M. M., Rome.
8. Carter, D. M., Madison.
9. Bennett, J. C., Jefferson.
10. Lee, F. Lansing, Augusta.
11. Penland, J. E., Waycross.
12. Cheek, O. H., Dublin.

### HONOR ROLL

The following is a list of 100 per cent counties for 1925. The date on which each became a 100 per cent society appears after the name of the society, together with the name of the Secretary:

1. Randolph County, Dr. G. Y. Moore, Cuthbert, December 9, 1924.
2. Dougherty County, Dr. J. A. Redfearn, Albany, December 10, 1924.
3. Pike County, Dr. M. M. Head, Zebulon, December 12, 1924.
4. Hart County, Dr. W. E. McCurry, Hartwell, January 3, 1925.
5. Warren County, Dr. A. W. Davis, Warrenton, January 14, 1925.
6. Monroe County, Dr. W. J. Smith, Juliette, January 14, 1925.
7. Lamar County, Dr. John M. Anderson, Barnesville, March 6, 1925.
8. Upson County, Dr. B. C. Adams, Thomaston, March 30, 1925.
9. Emanuel County, Dr. S. S. Youmans, Oak Park, May 5, 1925.
10. Stephens County, Dr. C. L. Ayers, Tooeoa, May 11, 1925.
11. Turner County, Dr. J. H. Baxter, Ashburn, May 12, 1925.
12. Evans County, Dr. D. S. Clanton, Hagan, May 14, 1925.

### TRI-COUNTY MEDICAL SOCIETY

The Tri-County Medical Society enjoyed a big day on the tenth of June. We were favored with a visit by the Medical Extension Board from the University Medical Department, composed of Doctors W. P. Sydenstricker, W. A. Mulherin and W. N. Hoyt, all of Augusta.

In the forenoon Dr. Sydenstricker conducted the clinic for medical cases; two cases of diabetes were considered. Blood was taken from these and blood-sugar estimates

made, one showing a very high blood-sugar and the other showing a normal blood-sugar with sugar appearing in the urine. Several other cases of a medical nature were examined and symptoms analyzed.

In the afternoon children were considered by Dr. Mulherin and the various disorders of childhood were informally taken up and a general discussion resulted much to the enlightenment of the Society and its members.

At night Dr. Hoyt gave an illustrated public health lecture, and the public attended. The lecture was well received and it is regretted that more were not present, as the lecture was full of things the public ought to know. At the noon hour there was an old-fashioned fish-fry at Nanee's Spring, where a number enjoyed the delightfully cool waters in the swimming pool.

The Society members have been greatly benefited by these visitors, and it is hoped that we can have them with us again.

C. K. SHARP, Secretary.

### MACON-TAYLOR COUNTIES MEDICAL SOCIETY

The doctors in Macon and Taylor counties held a meeting June 6, 1925, in Montezuma.

Instructive papers were read by Dr. S. H. Bryan, Reynolds, "Hay Fever"; and Dr. C. H. Richardson, Sr., Montezuma, "Intestinal Disturbances of Infants."

This Society will recommend the employment of a full-time health officer for the two counties at the next session of the grand jury of Macon and Taylor counties. They will also recommend an increased appropriation for the State Board of Health, stating that more money is appropriated by the State of Georgia to fight hog cholera and for tick eradication than for the control of contagious diseases among children.

Dr. C. A. Greer, Oglethorpe, was re-elected

President, and Dr. F. M. Mullino, Montezuma, Secretary-Treasurer. The doctors were entertained at luncheon by the Kiwanis Club.

### GEORGIA MEDICAL SOCIETY

At the regular meeting of the Georgia Medical Society (Chatham County), May 25, 1925, held at its home in Savannah, plans were discussed for the annual mid-summer meeting, which is to be held August 1. The following two committees were appointed to make arrangements for this meeting:

Program Committee: Dr. A. J. Waring, Chairman; Dr. Chas. Usher and Dr. M. J. Egan.

Entertainment Committee: Dr. D. B. Edwards, Chairman; Dr. C. F. Holton, Dr. R. V. Howard, Dr. J. R. Graves, Dr. E. C. Diamond and Dr. W. H. Myers.

The delegates to the annual meeting of the State, held in Atlanta during May, made their reports.

Dr. A. J. Waring gave an interesting talk on the proper footwear for children. He showed several types of shoes as illustrations. This was followed by refreshments and the meeting adjourned at 10:30 o'clock.

### FULTON COUNTY MEDICAL SOCIETY

An unusually interesting meeting of the Fulton County Medical Society was held May 21, 1925, at the Academy of Medicine, 32 Howard St., Atlanta. Dr. Theo. Toepel presided, and there were 110 present.

A case report, "Intestinal Obstruction," was given by Dr. Linton Smith and discussed by Drs. Fuller and Willis Jones.

An address by Prof. W. A. Sutton on the matter of "Health and Education," was greatly enjoyed by everyone.

The paper of the evening was read by Dr. T. C. Davison, "Treatment of Goitre." This was discussed by Drs. C. W. Strickler, Hines Roberts, C. W. Roberts, Willis Jones and W. A. Selman.

After the report of the Committee on Arrangements, Dr. Theo. Toepel, President, took this occasion to express his gratification and appreciation of the wonderful work of this Committee and of the fine spirit shown by all in putting over the Convention, also the la-

dies of the Ladies' Auxiliary to the Fulton County Medical Society were to be commended for their splendid entertainments and hospitality.

As there was no further business to come before the Society at this time, the meeting adjourned.

Another regular meeting of the Society was held at the Academy of Medicine, 32 Howard St., June 4, 1925, at 8 P. M. Dr. Theo. Toepel, President, presided, and 78 were present.

The presentation of a very interesting case by Dr. G. P. Huguley, "Empyema of Gall-Bladder; Lobar Pneumonia, right; Empyema of Pleura; Pulmonary Abscess; in Patient Nine Years of Age." This was discussed by Drs. T. C. Davison, R. R. Daly, M. T. Benson, C. W. Roberts. Dr. J. O. Kinard gave a case report of "Pre-Operative Sudden Death," which was discussed by Drs. M. T. Benson and H. R. Donaldson. "Two Unusual Post-Operative Fatalities" was reported by Dr. Willis Jones and discussed by Drs. G. P. Huguley, C. C. Aven, N. W. Baird and T. C. Davison. Dr. Harry Vaughn gave a clinical talk, "Paralytic Ileus," which was discussed by Dr. J. O. Kinard. Dr. Hal M. Davison read the paper of the evening, "Non-Specific Treatment of Hay Fever." This was discussed by Drs. H. C. Sauls, G. D. Ayer, B. McH. Cline, A. H. Bunce, R. R. Daly and O. O. Fanning.

Under the reports of committees, the Public Health Committee reported on work accomplished during the recent Health Week, in placing before the public through addresses to the different Parent-Teacher bodies throughout the county, civic clubs, giving radio talks and addresses by different doctors at the church services held throughout the county on Sunday, May 10. These talks contained information for the general public concerning Preventive Medicine and 60 per cent of the pulpits in this county were filled for this purpose on that date. On Friday of Health Week a Health Parade was staged in which thirty floats participated.

Motion to adjourn.

Respectfully submitted,  
GRADY E. CLAY, Secretary.



## COUNTY SOCIETIES REPORTING FOR 1925

### Muscogee County Medical Society

The Muscogee County Medical Society announces the following officers for 1925:

President—W. P. Jordan, Columbus.

Vice-President—J. C. Wooldridge, Columbus.

Secretary-Treasurer—F. B. Blackmar, Columbus.

Delegate—J. M. Anderson, Columbus.

Alternate—W. L. Cook, Columbus.

### Meriwether County Medical Society

The Meriwether County Medical Society announces the following officers for 1925:

President—J. A. Johnson, Manchester.

Vice-President—V. H. Bennett, Gay.

Acting Secretary-Treasurer—R. B. Gilbert, Greenville.

Delegate—R. B. Gilbert, Greenville.

### Twiggs County Medical Society

The Twiggs County Medical Society announces the following officers for 1925:

President—T. S. Jones, Jeffersonville.

Secretary-Treasurer—H. A. Rogers, Jeffersonville.

### Taliaferro County Medical Society

The Taliaferro County Medical Society announces the following officers for 1925:

President—John A. Rhodes, Crawfordville.

Vice-President—Thos. C. Nash, Philomath.

Secretary-Treasurer—Alex H. Beazley, Crawfordville.

## WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

### Minutes of the Annual Meeting of Delegates, May 13, 1925

At 10:30 A. M., May 13, 1925, the delegates to the Woman's Auxiliary to the Medical Association of Georgia met at the Hotel Biltmore, Atlanta, Mrs. James N. Brawner, President, in the Chair; Mrs. Allen H. Bunec, Secretary. The minutes of the organization meeting in Augusta were read and approved.

The meeting was devoted entirely to discussing the Proposed Constitution and By-Laws, the Delegates' Reports and the per capita assessment of the County Auxiliaries to the State Auxiliary.

Mrs. C. W. Roberts, Chairman of the Committee on Constitution and By-Laws, made her report and the following changes were adopted:

#### Constitution

Article IV, Section III. Change "Societies" to "Auxiliaries," making it read "Component Auxiliaries."

Article VII, Section I. Make the change: "District Vice-Presidents" to "District Managers." Combine the offices of the Secretary and the Treasurer, that officer to be known as Secretary-Treasurer.

Article VII, Section II. Change to read: "These officers shall be elected annually by ballot at the annual meeting. A Nominating Committee shall be elected by the Executive Committee to present a list of officers; this Nominating Committee to be composed of seven members, three from the Executive Committee and four from the general body.

This will not exclude nominations from the floor." Remainder of Section II as is.

Article VIII. Change first and second sentences to: "Funds appropriated by the Executive Committee to the District Managers shall be limited to stationery and postage.

#### By-Laws

Chapter I, Section II. Insert "If a physician has died while a member in good standing in the Medical Association of Georgia, his widow shall be eligible for membership under the same conditions as are contained in Section I."

Chapter I, Section III. Change to read "If no County Auxiliary exists any eligible member may become a member from the State-at-large by paying an annual fee of \$1.50 to the State Auxiliary.

Chapter IV, Section III. Change "Treasurer" to "Secretary-Treasurer."

Chapter IV, Section IV. Change "Secretary" to "Secretary-Treasurer."

Chapter V, Section II. Change "Vice-President" to "District Manager."

Chapter V, Section III. Change "Treasurer" to "Secretary-Treasurer."

Chapter V, Section IV. Change "Vice-President" to "District Manager."

Chapter VI shall read: "All standing committees to be decided upon by the Executive Committee."

Chapter VII to read: "A per capita tax of 50c shall be assessed each component Auxiliary as dues to the State Auxiliary.

A recess was taken during the reading of

this report to enable Dr. Theodore Toepel, the President of the Fulton County Medical Society, to welcome the delegates to the meeting and to explain the value of the magazine *Hygeia*, which is published by the American Medical Association. He stated that one of the most effective ways of proving the Auxiliary's worth and help to the Medical Association of Georgia would be the placing of *Hygeia* in the Public Libraries, news stands, schools, etc., and emphasized the fact that we should all become subscribers to it.

Mrs. W. H. Myers, District Manager from the First District, read a very fine report of her work during only a few weeks' time, as her appointment became effective a short time before the meeting. Three of her counties have organized and delegates from all three were in attendance at this meeting.

There were no reports from the Second, Third and Fourth Districts.

Mrs. C. W. Roberts, District Manager from the Fifth District, reported that she had visited all five counties in her territory and had found that most of the physicians were members of the Fulton County Medical Society, therefore, their wives were eligible for membership in the Woman's Auxiliary to the Fulton County Medical Society and they preferred it that way.

Mrs. C. H. Richardson, District Manager from the Sixth District, reported that Bibb County had recently organized and that she expected to successfully organize the other counties during the District meeting in June at Indian Springs.

There was no report from the Seventh District.

Mrs. Paul Holliday, District Manager from the Eighth District, reported a very enthusiastic and rapidly growing Auxiliary in Athens. The time has been too short to do much organization work in other counties.

Mrs. J. H. Downey, District Manager from the Ninth District, reported four organized counties and one still uncertain. With a little more time Mrs. Downey expects to get all of her counties in line.

There were no reports from the Tenth and Eleventh Districts.

Mrs. T. C. Thompson, District Manager

from the Twelfth District, reported that due to lack of time the organization work has been limited but during the ensuing year she felt that her counties would respond and become organized.

Adjourned at 12:45 P. M.

MRS. ALLEN H. BUNCE,

Secretary.

#### **Minutes of the Meeting of the Executive Committee, May 13, 1925**

At 1:30 P. M., on May 13, 1925, at the Hotel Biltmore, Atlanta, following a beautiful luncheon given by Mrs. James N. Brawner, at which Mrs. Seale Harris, of Birmingham, was guest of honor, occurred the First Annual Meeting of the Executive Committee. Mrs. Allen H. Bunce was elected Chairman.

The matter of Standing Committees was discussed at length and only three were decided upon for the ensuing year, namely: Program Committee, Committee on Legislation, Committee on Public Health and Public Education.

The Nominating Committee was then appointed with Mrs. J. H. Downey as Chairman. Mrs. Downey very wisely suggested that we concentrate our efforts in promoting only one or two phases of welfare work rather than scatter our energies in too many directions.

Due to the lateness of the hour, no other business was taken up.

Adjourned.

MRS. ALLEN H. BUNCE, Chairman,

Secretary.

#### **Minutes of the General Meeting, May 14, 1925**

At 10 o'clock Thursday morning, May 14, 1925, was held the first General Meeting of the Woman's Auxiliary to the Medical Association of Georgia at the Auditorium of the Woman's Club, Atlanta. Mrs. James N. Brawner, President, in the Chair, Mrs. Allen H. Bunce, Secretary.

An inspiring invocation was given by Dr. J. Sprole Lyons, of Atlanta, after which Mrs. Norman Sharp, President of the Atlanta Woman's Club, delivered the address of welcome. Mrs. E. C. Thrash, the President of the Auxiliary to the Fulton County Medical Society, paid a brief but loving tribute to the

assembled members. Mrs. W. H. Myers, of Savannah, responded to these addresses in her habitual effective and charming manner. Dr. Stewart R. Roberts, Atlanta, President of the Southern Medical Association, then delineated for us the many ways in which the Auxiliary could become a great help to the Medical Societies. Dr. T. F. Abererombie, Commissioner of Health of the State of Georgia, defined at length "The Healthy Child Personality" and presented a mass of statistics that should cause us all to think. He promised to have many copies of his address multigraphed and distributed among the Auxiliaries. Mrs. C. W. Roberts made her report on the Constitution and By-Laws. No discussions. Adopted.

Mrs. Seale Harris, of Birmingham, brought us a timely message about the organization work in other States. Mrs. James N. Brawner, President, then delivered her Presidential Address in which were expressed the lofty ideals that have characterized her administration for the first year of the Auxiliary. The Secretary read the financial report. Mrs. J. H. Downey, Chairman of the Nominating Committee, presented her report. Mrs. W. H. Myers, of Savannah, was nominated for President; Mrs. A. J. Mooney, of Statesboro, for Secretary. Both were elected unanimously and this Auxiliary feels very grateful to the Nominating Committee on its selection of officers. Our friendship, love and full co-operation we pledge them at all times.

Adjourned.

MRS. ALLEN H. BUNCE,  
Secretary.

### Secretary's Report

During this first year of existence the work of the Auxiliary has been confined to the exchange of personal letters, the sending of the Proposed Constitution and By-Laws, and such other literature as was deemed necessary for the information of its desired members. No dues were assessed, excepting the dues of \$1.00 each from the members of the State at large, that being the sum designated in the By-Laws, Chapter 1st, Section 2.

### Receipts

Members' dues ..... \$ 20.00

### Disbursements

By the President as per attached slip. 41.25  
By the Secretary as per attached slip. 90.95

To the Habersham County Auxiliary  
on account of payment of \$1.00 per  
capita whereas amount assessed be-  
ing 50c per capita ..... 6.00

---

Amount expended above receipts ..... \$148.10  
\$128.10

### Disbursements by the President, Mrs. J. N. Brawner—1924-1925

Multigraphing ..... \$ 6.00  
Multigraphing ..... 3.00  
Letterheads and Envelopes ..... 9.75  
Plain Stationery ..... 2.50  
Stamps ..... 4.00  
Stamps ..... 6.00  
Stamps ..... 10.00

---

\$41.25

### Disbursements by the Secretary, Mrs. A. H. Bunce—1924-1925

Dues to Woman's Auxiliary to A.M.A. \$ 5.00  
Stationery and Letterheads ..... 35.75  
Proposed Constitution and By-Laws 20.00  
Cards and Envelopes ..... 1.20  
Multigraphing ..... 2.00  
Stamps ..... 12.00  
Auxiliary Headquarters Biltmore Hotel 11.00  
Credential Cards ..... 4.00

---

\$90.95

## MEMBERSHIP LIST

### State Dues Paid Before Annual Meeting From the State at Large

1. Mrs. E. M. Bailey, Aeworth, Ga.
2. Mrs. Logan Thomas, Dawson, Ga., R. F. D. A—Box 50.
3. Mrs. J. K. Quattlebaun, Savannah, Ga., 906 E. Henry St.
4. Mrs. W. H. Lucas, Stillmore, Ga.
5. Mrs. W. W. Battay, Jr., Augusta, Ga.
6. Mrs. J. L. Walker, Waycross, Ga.
7. Mrs. S. A. Boland, Thomson, Ga.
8. Mrs. Stewart D. Brown, Royston, Ga.

### Habersham County

Mrs. O. N. Hardin, President, Cornelia, Ga.  
Mrs. P. Y. Duckett, Vice-President, Cornelia, Ga.  
Mrs. R. B. Lamb, Secretary-Treasurer, Demorest, Ga.  
Mrs. E. H. Lamb, Cornelia, Ga.  
Mrs. C. V. Chandler, Baldwin, Ga.  
Mrs. J. B. Jackson, Clarksville, Ga.



## NEWS ITEMS

We have just received a program of the 23rd annual meeting of the Wyoming State Medical Society, which was held in Buffalo, on June 22nd and 23rd. The following is an extract of the afternoon session: "5 p. m.—Annual Bath of the Wyoming Doctors and Dentists in the Buffalo Swimming Pool. (Bring your own bathing suits.)" We are publishing this for the information of our entertainment committee which will arrange the social program of our next meeting in Albany. Has Dougherty County a good swimming pool?

Dr. Francis B. Blackmar, the efficient Secretary-Treasurer of the Muscogee County Medical Society, and the Fourth District Society, joined Dr. MacKenzie, of Philadelphia and a party of eye, ear, nose and throat men in New York last month. From there they sailed for Vienna. Dr. Blackmar expects to return August 15th.

The many friends of Dr. J. H. Nicholson will be glad to learn that he will soon be back in Madison after having been in Pennsylvania for the past two years. Dr. Nicholson, before leaving Georgia, had been the capable Secretary-Treasurer of Morgan County Medical Society.

Dr. William Simpson Elkin, Atlanta, has resigned as dean of the Emory University School of Medicine after having served it faithfully and untiringly for the past 43 years. This action was caused by the press of his private practice and other responsibilities. Dr. Elkin's resignation was accepted with regrets and he was elected emeritus dean and emeritus professor of obstetrics and gynecology of the University. Dr. Russell H. Oppenheimer, Superintendent of the Wesley Memorial Hospital, was named dean, this change coming into effect June 9th.

Dr. Bernard McH. Cline announces the removal of his offices to Suite 1120-1121 Candler Building, Atlanta. Practice limited to eye, ear, nose and throat. Dr. Cline is a member of the Fulton County Medical Society.

Dr. George F. Klugh, Atlanta, read a paper, "The Practical Application of Blood Chemistry", by request before the Laurens County Medical Society, Clinton, South Carolina, June 22nd. Dr. Klugh is a past Secretary-Treasurer and President of this Society.

In a letter from Dr. H. G. Weaver, Macon, Secretary of the Bibb County Medical Society,

we are informed that Dr. A. B. Jemison has removed from Macon and is now with the Georgia Military College at Milledgeville, and that Dr. J. M. Moore has also removed from Macon and is practicing in Pompano, Fla.

Dr. J. T. Moore has taken up his practice of Genito-Urinary work in Tampa, Florida, having removed from Sycamore. He is still retaining his membership in the Turner County Medical Society, of which he was Secretary-Treasurer for the past several years.

Dr. H. M. Fullilove, our newly elected 2nd Vice-President, of Athens, was made President of the Association of Prison Physicians of Georgia at its annual meeting held in May. Dr. T. S. Bailey, of Newnan, was elected Vice-President and Dr. M. M. Head, who is Councillor of the Sixth District, was nominated as Secretary-Treasurer. Dr. Fullilove succeeded Dr. R. L. Miller, Waynesboro, who was elected 1925 Delegate to the A. M. A.

Dr. I. M. Lucas has returned from taking a post-graduate course at the New York Post-Graduate Medical School and Hospital, New York, and is located at 910 N. Madison Street, Albany, having removed from Towns. Dr. Lucas is Vice-President of the Telfair County Medical Society and its members regret that he has moved into Dougherty County.

Dr. J. A. Johnson has installed x-ray machines in the hospital in Manchester. Dr. Johnson is President of the Meriwether County Medical Society.

Dr. M. E. Winchester, Thomasville, and Dr. C. L. Ridley, Macon, were honored by the Medical School of the University of Georgia by having the degree of doctor of public health conferred upon them. Dr. Winchester is health commissioner of Thomas County and a member of the Thomas County Medical Society. Dr. Ridley is Bibb County Health Officer and a member of the Bibb County Medical Society.

At a meeting of the Randolph County Medical Society, June 4, 1925, papers were read by Dr. G. Y. Moore, Cuthbert, and Dr. W. W. Binion, Benevolence. Randolph was the first Society to report a 100% membership for 1925. Dr. Moore is Secretary-Treasurer and Dr. Binion is an honorary member.

Dr. Robert Drane, Dr. Lawrence Lee and Dr. and Mrs. H. C. Lang, all of Savannah, were among those attending the annual meeting of the American Medical Association in Atlantic City, N. J., May 25th to 29th.

Dr. R. L. Rhodes, Augusta, read a paper on "Hyperthyroidism" at the regular meeting of the Richmond County Medical Society, May 29, 1925. This paper was discussed by Drs. W. W. Battey, R. H. Chaney, W. A. Mulherin, all from Augusta; C. Thompson, Millen, with Dr. E. E. Murphey, Augusta, leading the discussion. Dr. Asbury Hull, Augusta, read a paper on "Infections of the Prostate". The discussion was led by Dr. C. W. Crane, Augusta, and followed by others from Drs. P. B. Wright, E. A. Wilcox, Augusta, and John W. Daniel, Savannah.

Dr. and Mrs. Raifold T. Warnock, of Atlanta, spent several days with relatives in Statesboro during June. Dr. Warnock is a new member of the Fulton County Medical Society.

Dr. O. H. Weaver, Macon, gave a talk at the dinner given to the members of the Staff of the Macon Hospital by the Junior Nurses. The dinner was a demonstration of the type of food served to the patients of the Hospital. Thirty of the members were present.

At the regular meeting of the Georgia Medical Society (Chatham County) last month a committee with Dr. W. H. Myers, Chairman, Drs. T. P. Waring, R. V. Martin, Chas. Usher and W. R. Dancy, all of Savannah, were appointed to investigate the advisability of making several minor improvements at the home of the Society on Drayton and Hull Streets, Savannah.

Drs. Eugene E. Murphey and H. W. Shaw were selected to appear before the Augusta Council to assist in appropriating \$6,000 to pay for public health nurses for Augusta. The matter was deferred until a later date.

Dr. Chas. E. Dowman, Atlanta, spoke at the semi-monthly meeting and banquet of the Calhoun County Medical Society, Anniston, Alabama, on "Classification of Treatment of Head Injuries", May 26, 1925. Dr. Dowman is a member of the Fulton County Medical Society.

The million-dollar John D. Archbold Memorial Hospital was opened to the public June 30th. An interesting program was arranged. Thomasville has a right to be proud of this as there is probably no town the size of Thomasville in this section of the country that has a building such as this for hospital purposes.

Fifty-nine medical students, all but three of them from Emory University, stood the medical examination June 10th for license to practice medicine in Georgia.

Dr. Tom A. Williams has removed from Miami, Florida, and returned to Washington, D. C. Practice limited to Diseases of the Nervous System.

The Inter-State Post Graduate Assembly of America will be held at St. Paul, Minnesota, October 12-16, 1925.

### GORGAS MEMORIAL

Beginning early in May with the Special Medical Societies which constitute the membership of the Congress of American Physicians and Surgeons, the progress of the Gorgas Memorial Institute has been publicly reported to many interested groups.

The same program is being continued during May among the State Medical Societies and will be extended into June.

The Memorial was congratulated for its able work in urging the recognition of scientific medicine as the only authority in health matters, especially at a time, when influence of this kind is needed in so many communities of every state.

In Washington at the Congress of American Physicians and Surgeons, a representative of the Gorgas Memorial Institute publicly thanked the state and special medical journals and county society bulletins for their generous allotment of space to Gorgas Memorial news. Their cooperation, it was explained, had brought the Gorgas program before many doctors, who otherwise, owing to a limited field organization, would not have been reached.

"The Gorgas Memorial", the representative stated, "has passed the experimental stage. It is demonstrated that the public is willing and anxious to be guided in matters of health by the real authority—the scientific medical profession. People are entitled to proper health information furnished them in conservative, ethical interesting ways, from a reliable source. A program of this kind cannot be developed by the individual physician. But the Gorgas Memorial affords the channel through

which it can be done. Judging from the response to our effort of the past four months, it appears we have struck the right note with lay public as well as the profession.

"It is only by educating the individual in the truths of scientific medicine that the various irregular cults can be checked and that improper medical legislation can be obstructed. We want your help—we want your advice—we want your association in developing the Gorgas Idea. You can render aid most effectively by becoming a member of your State Governing Board. Many of you are already members. I urge you to immediately respond in order that we may expand the Gorgas program to the fullest extent as quickly as possible.

### DOCTORS AND NATURALISTS UNITE FOR MEMORIAL DRIVE

**\$100,000 to be Raised in Commemoration of Ernest Harold Baynes**

A distinguished group of doctors and naturalists have banded together for the purpose of raising a memorial fund to the memory of Ernest Harold Baynes, author, lecturer, poet, lover of birds and animals and of all mankind. Mr. Baynes died at his home in Meriden, N. H., on January 21st of this year.

The debt of both doctors and naturalists to Mr. Baynes is a heavy one. It was Mr. Baynes who started the society that saved the American bison from extinction; who organized nearly 300 bird clubs in this country; who spent many months abroad during the world war studying the part played by the animals in helping to bring victory to the allied armies; and who did more perhaps than anyone else in stirring up popular interest in the great outdoors. Loving animals he investigated the sensational charges of the anti-vivisectionists, and finding them groundless gave unstintingly of his time and energy and made great financial sacrifices in an effort to combat anti-vivisection propaganda.

As much of the income from the fund as may be necessary will be paid, at the discretion of the committee, to Mr. Baynes' widow. The remainder, and at her death the principal, will go to the American Association for Medical Progress, that society which Mr. Baynes helped to organize for the dissemination of truth concerning the value of scientific medicine, and in which he was so interested at the time of his death. The fund will be administered by the First National Bank of Boston as Trustees.

### CHILE HAS A SOCIAL HYGIENE LAW

By the

United States Public Health Service

The Republic of Chile has recently enacted legislation for the control of venereal diseases. The law establishes a Division of Social Hygiene with three departments—Education, Control, and Healing. The various functions of this Division are definitely outlined.

The Department of Education is held responsible for special propaganda, for the study of educational programs, for the creation of social hygiene professorships in the medical schools, institutes, and normal schools, and for suggestions in elementary social hygiene instruction to be included in general public education. The Department of Education is also to direct the control and repression of prostitution, watch over the specialists in venereal diseases, exacting from them the certificate of competence the law requires, and to watch over the practices of public and private laboratories in investigations connected with the bacteriological and serological diagnosis of social diseases.

One of the sections of the Department of Control, the Office of Control of Prostitution, has for its function the control and repression of openly established and secretly practiced prostitution. It also watches over the morals of public resorts. The Office of Professional Control, another section in the same department, has control over the exercise of the practice of surgery as relating to social diseases. It exacts special licenses from physicians and laboratories.

The Department of Healing, through its Central Pharmacy Office, distributes medicines and curative materials to hospitals and clinics. It maintains a manufacturing laboratory for preparations needed by the pharmacies of the service. The same department maintains an Office of Clinical Statistics and an Office of Medical Information. The latter makes available information on medical progress in experimental investigation, diagnosis and treatment of venereal diseases, tuberculosis, alcoholism, physical education, and hygiene of dwellings; also, on progress of the fight against venereal diseases in different towns which distinguish themselves in this field. The formation of libraries and the supplying of magazines indispensable to the service are to be administered by the Office of Libraries and Magazines.

The Social Hygiene Brigades, one for each of the five zones into which the Republic of Chile is divided, have clinics and hospitals for venereal diseases, degenerates, and tuberculars. Provision is also made for Brigade Reformatories to render hospital service for those who have contagious diseases and who have refused treatment and compliance with the law.

The President of the Republic is authorized to incorporate programs of study in social hygiene



into the text books of all schools. The law also provides a penalty for private schools failing to provide such instruction.

Women practicing prostitution are submitted to medical inspection to verify their pathological condition. Any woman prostitute declared to have a venereal disease is confined to a hospital during the period of contagion. Those resisting treatment are sent to a reformatory. Treatment of venereal diseases is obligatory and provided at public expense, except in chronic cases. These are to be cared for by private physicians or charitable institutions authorized to do such work. A strict system of reporting of venereally diseased by private physicians is inaugurated. Provision is also made for injunction and abatement measures making it possible to close up as a nuisance any building which the owner allows to be used for purposes of prostitution. Professional or commercial proclamations relating to operations or advertisements of drugs and specifics for curing venereal diseases are not to be accepted for publication in newspapers and magazines, unless endorsed by the Division of Social Hygiene. A medical certificate of good health is required from both men and women before marriage.

#### **TREATMENT OF CHANCROID WITH TARTAR EMETIC SOLUTION INTRAVENOUSLY**

Herman Goodman, of New York City, proposes the use of solutions of tartar emetic intravenously in the treatment of chancroid, following his experiences with this drug in the tropics in the therapy of granuloma inguinale.

In Goodman's experience, the diagnosis of chancroid most often rests on clinical observation; absence of *Spirocheta pallida* on dark field examination; and absence of the so-called Calimato-baeterium granulomatis of inguinal granuloma. The search for Ducrey bacilli in smears has not been fruitful, and the utilization of culture methods has not been routine. The Wassermann reaction is of negative aid.

The patients have presented themselves for treatment after extension to the draining glands, and several after ineffective anti-syphilitic treatment. Other patients had been under observation for urethritis because of a purulent discharge exuding from an acquired phimotic prepuce. Goodman uses the actual cautery knife to make a dorsal slit when indicated rather than the cold knife because of the possible danger of open-

ing blood and lymph channels. Local cleanliness with soap and water, and immersion of the affected part in warmed mercuric chloride was insisted upon.

The innovation in treatment is the use intravenously of solutions of tartar emetic or antimony potassium tartrate. The drug is given in concentration of 1:100. A commercial sterilized one per cent solution, standardized and biologically tested, contained in 10 cc. hermetically sealed ampoules has been used. The initial dose intravenously has been 5 cc. of the 1:100 solution, given once every second day or at longer intervals to once in five days. The number of injections has varied from four to eight. The dose may be increased by 1 cc. at each injection, but no dose greater than 12 cc. has been administered. There have been no ill effects.

The use of antimony potassium tartrate in chancroid is recited in case histories. It is hoped that the experiences of others will warrant further publication.

Goodman's original paper appeared in the *Journal of Urology* (13:489), for April, 1925.

#### **IMPROVED METHOD FOR RABIES PREVENTION**

Time was, and not so very long ago, when a mad dog could terrorize a whole community; to be bitten by such an animal was not merely a death sentence, but a sentence to the most horrible of deaths. The resourcefulness and persistent energy of one man, a pioneer, has changed all this. Pasteur's method of preventing hydrophobia was indeed the dawning of a new day. Still, for many years it was necessary for the victims of mad-dog bites to be taken to "institutes" for treatment, and not only failure but injury from the treatment was possible.

A pioneer is most honored by those who catch his spirit and continue to go forward. The Pasteur method has been improved. "Institutes" are no longer necessary. Toxicity has been found to be no essential factor in the immunizing treatment, and Rabies Vaccine is now available that is incapable of injuring the patient, no matter what dose in the "course" is given first or last—all being alike. And, strange to say, this Vaccine has been demonstrated to confer a higher degree of immunity than the desiccated spinal cord originally used.

Our readers are referred to the advertisement in this issue entitled "The Prevention of Hydrophobia", and for more complete particulars to Parke, Davis & Co., Detroit, Mich., who have recently issued a free booklet on "Rabies Vaccine".

## Medical Progress

With the cooperation of our associates we propose to publish under "Medical Progress" abstracts from current medical literature of general interest to the

profession. Members of the association are invited to contribute to this Department.

Anderson, W. W., Pediatrics  
Ballenger, E. G., Urology  
Bartholomew, R. A., Obstetrics  
Block, E. B., Neurology and Psychiatry  
Clay, Grady E., Ophthalmology  
Dowman, C. E., Neuro-Surgery  
Eguen, M. S., Otolaryngology and Rhinology  
Fitts, Jno. B., Internal Medicine  
Greene, E. H., Surgery

Hodgson, F. G., Orthopedics  
Holmes, Walter R., Gynecology and Female Urology  
Jones, Jack W., Dermatology  
Klugh, Geo. F., Clinical Pathology  
Landham, J. W., X-Ray and Radium  
Pruitt, M. C., Proctology  
Thrash, E. C., Internal Medicine  
Waits, C. E., Surgery

### INTRACRANIAL TUMORS\*

Charles E. Dowman, M.D.,  
Atlanta, Ga.

From a clinical point of view any expanding lesion within the cranial cavity falls into the general group of intracranial tumors. The so-called granulomatous tumors will be considered in a general way at this time, and although chronic brain abscess might simulate the clinical manifestations of tumor of the brain, this lesion will be discussed in a subsequent lecture.

As the intracranial structures are encased within the non-expansible skull, it can be readily understood why symptoms indicative of increased intracranial pressure will sooner or later arise when the intracranial structures are encroached upon by an expanding lesion. Under certain circumstances it is possible for a brain tumor to attain considerable size before giving rise to the symptoms of increased intracranial pressure. This is made possible by the presence within the brain of fluid-filled cavities termed ventricles. These cavities may be encroached upon up to certain limits and the compensatory displacement of the fluid may often permit the intruder to develop unsuspected for a considerable period of time. In other words, the ventricles may become collapsed in order to allow room for the tumor and increased pressure will not occur until the growth reaches a proportion greater than the compensatory displacement of fluid. However, should the tumor be so located as to cause an obstruction to one or more of the channels through which the fluid from the ventricles must pass (as it circulates

towards the subarachnoid space from which it is normally absorbed), there will occur early in the progress of the disease the symptoms of increased intracranial pressure due to ventricular distention. It is thus apparent that the early appearance of these pressure symptoms depends not so much on the size of the tumor as on its location. For example, it is possible to have a very large tumor of the cerebral hemispheres without pressure symptoms; whereas, on the other hand, a tumor the size of a small marble so situated as to obstruct the Aqueduct of Sylvius with the resulting internal hydrocephalus, will give rise to the early appearance of the symptoms of increased intracranial pressure.

There is another factor which may determine whether or not early pressure symptoms are liable to develop. I refer to the character of the tumor. There is a type of glioma, for example, which replaces instead of displacing brain tissue. Such infiltrating tumors may attain enormous size before causing increased pressure. As a matter of fact the first symptoms of such tumors may be caused by a large hemorrhage occurring within the growth. A tumor of the pons would be expected to give rise to pressure symptoms very early in its development on account of the close proximity of the Aqueduct of Sylvius; and such is usually the case. I have in my collection of brain tumors a large glioma of the pons which was accurately located before death, and the patient had never had a headache, and at autopsy the lateral ventricles were normal in size. The tumor had infiltrated the pontile structures, and although the aqueduct was encroached upon, complete closure had not been effected.

Although brain tumors may not infrequent-

\*This is one of a series of lectures on Neurological Surgery, delivered to the senior students, Medical Department of Emory University.

ly fail to give rise to the classic symptoms of increased intracranial pressure until late in the disease, it is fortunately possible to suspect intracranial tumor on account of the presence of so-called *focal symptoms*. In order for focal symptoms to be present, however, the tumor must be located in one of the areas of the brain, the function of which is clearly understood; or such an area must be involved by pressure or extension from an expanding lesion in the immediate neighborhood. For example, a tumor located in that area of the brain where the memory of spoken language is stored will cause the patient to have an auditory aphasia; a tumor located in the center for the movements of the hand will cause either jacksonian manifestations of the hand or a monoplegia, or a combination of both irritative and destructive phenomena, etc. Unfortunately there are many areas of the brain, the function of which is not clearly understood. When a tumor is located, therefore, in one of these so-called "silent areas" it may not be suspected until neighboring areas of known function are involved, or until the symptoms of increased intracranial pressure appear.

Although it is often easy to suspect the presence of brain tumor, and with the aid of the various diagnostic methods, it is possible in the great majority of the cases to accurately locate the lesion, it is, as a rule, little more than a hazardous guess to speculate concerning the exact nature of the lesion. Such speculations are based on certain statistical information gathered from the literature or from our own personal experience. For example, we know that of the tumors involving the pons and cerebellum in children, the most common are the tuberculomas. Unless, however, such a granulomatous tumor contains enough calcium salts to cause a shadow to be depicted on the roentgen film, one could not say definitely that the lesion is not a glioma or an endothelioma.

The history of the duration of symptoms may help to a certain extent in our speculations in regard to the nature of the growths. For example, we know that endotheliomas, as a rule, are slowly growing, non-malignant, encapsulated tumors, whereas gliomas are

usually more rapidly growing and more malignant in character, and therefore usually of shorter duration. Those tumors which occur in the cerebellar pontile angle usually originate from the acoustic nerve and give rise to such a characteristic symptomatology that the nature of cerebellar pontile angle tumors can usually be accurately predicted. The nature of the average infra- and suprachiasmal tumor can be fairly accurately determined. The infrachiasmal tumors are of pituitary origin and are as a rule either adenomas or cysts; the various clinical manifestations of glandular hypo- or hyperactivity furnish excellent data for predicting the nature of the growth. When the suprachiasmal tumor casts a shadow on the roentgen film, the lesion is usually a cyst originating from the remains of an embryological structure known as the cranio-pharyngeal duct. Endotheliomas originating from the dura are likely to cause (probably through irritation) a thickening of the overlying skull; such a bony overgrowth can often be felt and when present should always cause one to suspect an underlying endothelioma.

It is naturally of great clinical importance to differentiate, if possible, the neoplasms proper from the granulomas. This is not always an easy matter. The occurrence of tuberculoma in the pons and the cerebellum in children has already been mentioned. The frequency of gumma of the brain unfortunately has been greatly over-emphasized in various text-books. As a matter of fact, gummata of the brain are of very infrequent occurrence. On account of the wrong impression in regard to the relative frequency of gumma, many physicians consider it justifiable to give antisyphilitic treatment to all cases presenting symptoms of brain tumor. The objection to such a procedure is that much valuable time is lost before the correct diagnosis is made. Should antisyphilitic treatment be given such cases without the positive serological evidence of syphilis, a time limit of three weeks should be adhered to, so that operative measures may not be further delayed in those cases which do not respond promptly. The history of syphilitic infection and the positive evidence of syphilis on blood



or spinal fluid examination should naturally lead one to suspect an intracranial lesion as being syphilitic. Gummata affect primarily the meninges and secondarily involve the brain proper. Conglomerate tubercles on the other hand are always found surrounded by brain tissue and involve the meninges only during the last stages of the disease. When this occurs the symptoms are those of a generalized tuberculous meningitis.

**INCIDENCE:** Intracranial tumors are unquestionably more frequent than is generally suspected. It has been estimated that about 2 per cent of all individuals coming to autopsy have some type of brain tumor. This is probably too small an estimate, as it is quite possible that the usual cursory examination of the brain will fail to disclose many infiltrating gliomata. In the fresh specimen it is often difficult to differentiate an infiltrating glioma from normal brain tissue; unless the lesion has been suspected before death, therefore, such a condition may be overlooked by the pathologist. As the brain and its coverings are not infrequently the sites of new-growths, every practitioner of medicine will probably have such conditions to occur in his practice. Unless, therefore, the general clinical picture produced by such lesions be kept in mind, many such cases will continue to go undiagnosed.

**ETIOLOGY:** As much obscurity concerning the cause of brain tumor exists as in tumors in other parts of the body. The etiology of the various granulomas is of course self-evident. These granulomas (tubercle, syphiloma, actinomycosis) probably occur in the brain after lymphatic invasion. Cysticercus cysts of the fourth ventricle occasionally occur. Such lesions are the result of invasion by the cysticercus cellulose from other infected areas. The occurrence of metastatic carcinoma and sarcoma from some primary though remote growth can likewise be explained. The occurrence of those rare tumors which arise from embryonic cell-rests or the remains of embryonic structures can likewise be understood. These tumors are teratomata, chordomata, dermoids, and cysts of the cranio-pharyngeal ducts. They are

usually located in the base of the brain and skull.

The factors responsible for the occurrence of the primary neoplasms of the brain and meninges (glioma, endothelioma, acoustic neurinoma) are as yet unknown. That such tumors are the result of trauma has naturally been advanced. It is quite true that very frequently there is a history of head trauma at some previous time in cases of brain tumor; and the fact that brain tumor is more frequent in men (who are more liable to trauma) than in women, lends argument in favor of trauma as an etiological factor. This, however, is but feeble proof. When a blow on the head is followed by symptoms that are suggestive of tumor, it is quite likely that the patient already had an infiltrating glioma which in such a case might cause a hemorrhage within the tumor, with consequent clinical manifestations. The trauma theory, therefore, is purely speculative and can not be definitely proven.

(To be continued)

## BOOKS RECEIVED

**Modern Surgery** (General and Operative) by John Chalmers DaCosta, M.D., LL.D., F. A. C. S. Samuel D. Gross, Professor of Surgery, Jefferson Medical College, Philadelphia. Ninth Edition. Revised and Reset. Octavo of 1527 pages with 1200 illustrations, some in colors. Philadelphia and London: W. B. Saunders Company, 1925 cloth, \$10.00 net.

**Nineteen-Twenty-four Papers of the Mayo Clinic and the Mayo Foundation**, Rochester, Minnesota. Octavo of 1331 pages, 254 illustrations. Philadelphia and London: W. B. Saunders Company, 1925. Cloth, \$13.00 net.

**Physical Diagnosis of Diseases of the Chest**—By Joseph H. Pratt, A.M., M.D., and George E. Bushnell, Ph.D., M.D. Octavo of 522 pages with 166 illustrations. Philadelphia and London: W. B. Saunders Company, 1925. Cloth, \$5.00 net.

**The Surgical Clinics of North America** (New York Number—April, 1925). Issued serially, one number every other month. Volume V, Number II, 337 pages with 105 illustrations. Per clinic year (February, 1925, to December, 1925). Paper, \$12; Cloth, \$16 net. Philadelphia and London: W. B. Saunders Company.

**A Manual of Physical Diagnosis**—By Austin Flint, M.D., LL.D., late Professor of the Principles and Practice of Medicine and of Clinical Medicine in Bellevue Hospital Medical College, etc. Ninth Edition, Revised by Henry C. Thacher, M.S., M.D., Attending Physician, Lincoln Hospital, and Assistant Attending Physician, Roosevelt Hospital, New York. Illustrated. Price \$3.00. Publishers: Lea & Febiger, Philadelphia and New York.

---

### BOOK REVIEWS

**New and Nonofficial Remedies, 1925**, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1925. Cloth. Price, postpaid, \$1.50. Pp. 461+XL. Chicago: American Medical Association, 1925.

New and Nonofficial Remedies is the publication of the Council on Pharmacy and Chemistry through which this body annually provides the American medical profession with disinterested critical information about the proprietary medicines which are offered to the profession and which the Council deems worthy of recognition. The book also contains descriptions of nonproprietary medicines which the Council considers worthy of consideration.

In addition to a statement of the actions, uses and dosage of each product, many of these are arranged in classes and these classes are introduced by a general discussion of the group; thus the silver preparations, the iodine preparations, the arsenic preparations and the biologic products are preceded by a thoroughly up-to-date discussion of the group.

A glance at the preface shows that, in addition to the description of the new drugs

which were accepted during the past year, the book has been extensively revised; many of the preparations listed in the previous edition have been omitted and the statements of the properties of others have been revised to bring the descriptions in accord with present-day knowledge. Of particular interest is the revision of the general articles; thus the article on endocrine products has been entirely rewritten to bring this chapter in accord with the series of articles on glandular therapy which were published in 1924 under the auspices of the Council. A general article on medicinal dyes has been added.

A section of the book (brought up-to-date each year) gives references to proprietary articles not accepted for New and Nonofficial Remedies. This list, in conjunction with the book proper, constitutes a cumulative index of proprietary medicines which physicians may consult when some proprietary product is brought to their attention.

Physicians cannot dispense with the newer remedies that are being brought out, yet they can neither judge them on the basis of the manufacturers' claims nor have they the opportunity or time to determine their merits. For this reason every physician should possess a copy of the annual volume of New and Nonofficial Remedies which the Council on Pharmacy and Chemistry puts at his disposal.

---

### OBITUARY

Dr. Felix C. Johnston, 871 Mulberry Street, Macon, died at the Macon Hospital May 25, 1925. Dr. Johnston was struck by a street car at 5:30 and died within two hours after the accident. He had been practicing in Macon for the past twenty years up to a year ago. He was 70 years of age and had been a member of the Bibb County Medical Society for many years.

Dr. L. Robard, after a long illness, died at his home in Villa Rica, May 27, 1925. He was one of the oldest residents of Villa Rica, being 78 years of age. He had been one of the most prominent physicians for a number of years but for the past several years had led a retired life. Dr. Robard was also a leader in religious work, having been a Baptist preacher.

# Members Registering at Annual Meeting Held in Atlanta, May 13, 14, 15, 1925.

**A**

Abercrombie, T. F., Atlanta.  
 Adams, C. B., Atlanta.  
 Adams, C. R., Atlanta.  
 Adams, F. L., Elberton.  
 Adams, H. M. S., Atlanta.  
 Adkins, W. N., Atlanta.  
 Aderholdt, W. A., Carrollton.  
 Aiken, W. S., Atlanta.  
 Allen, L. C., Hoschton.  
 Allen, M. B., Hoschton.  
 Amis, F. J., Jr., Hogansville.  
 Anderson, J. M., Columbus.  
 Anderson, W. W., Atlanta.  
 Ansley, W. S., Decatur.  
 Applewhite, J. D., Athens.  
 Armstrong, T. B., Atlanta.  
 Arnold, W. A., Atlanta.  
 Askew, H. H., Atlanta.  
 Aven, C. C., Atlanta.  
 Avary, J. C., Atlanta.  
 Aycock, Mell, Atlanta.  
 Ayer, G. D., Atlanta.  
 Ayers, A. J., Atlanta.  
 Ayers, C. L., Toccoa.

**B**

Baggett, L. C., Atlanta.  
 Bagley, D. A., Austell.  
 Bagley, Geo. W., DeSoto.  
 Bailey, E. M., Acworth.  
 Bailey, T. S., Union.  
 Baker, L. A., Tifton.  
 Baker, W. P., Atlanta.  
 Ballenger, E. G., Atlanta.  
 Ballenger, W. L., Atlanta.  
 Barber, W. E., Atlanta.  
 Barfield, F. M., Atlanta.  
 Barker, N. L., Atlanta.  
 Barnett, Steve, Atlanta.  
 Barrow, Craig, Savannah.  
 Barrow, H. L., Macon.  
 Bartholomew, R. A., Atlanta.  
 Battey, W. W., Jr., Augusta.  
 Beasley, B. T., Atlanta.  
 Belcher, F. S., Montezuma.  
 Bennett, J. C., Jefferson.  
 Bennett, V. H., Gay.  
 Benson, M. T., Atlanta.  
 Benson, W. E., Marietta.  
 Best, P. W., Atlanta.  
 Bird, Frank, Valdosta.  
 Bivings, F. Lee, Atlanta.  
 Blackman, W. W., Atlanta.  
 Blackmar, Francis B., Columbus.  
 Blincoe, H., Atlanta.  
 Boland, Chas. G., Atlanta.  
 Boland, Frank K., Atlanta.  
 Boring, J. R., Canton.  
 Bowdoin, J. P., Adairsville.  
 Boyd, M. L., Atlanta.  
 Bradley, R. H., Chatsworth.  
 Bray, H. B., Wrightsville.  
 Bray, S. E., Savannah.  
 Brawner, A. F., Atlanta.  
 Brawner, Leon E., Atlanta.  
 Brawner, J. N., Atlanta.  
 Brice, J. T., Atlanta.  
 Brooke, Geo. C., Canton.  
 Brown, J. A., Shady Dale.  
 Brown, S. D., Royston.

Brown, S. T., Atlanta.  
 Brown, W. T., Atlanta.  
 Buff, J. H., Atlanta.  
 Bunce, Allen H., Atlanta.  
 Burdette, J. R., Tennille.  
 Burns, J. K., Jr., Gainesville.  
 Busey, T. J., Fayetteville.  
 Bush, O. B., Atlanta.  
 Byne, J. M., Waynesboro.  
 Byrd, E. S., Atlanta.  
 Byrd, H. O., Atlanta.

**C**

Cabaniss, W. H., Athens.  
 Caldwell, A. F., Atlanta.  
 Calhoun, Phinizz, Atlanta.  
 Callaway, J. T., Atlanta.  
 Camp, R. T., Fairburn.  
 Camp, W. R., Fairburn.  
 Campbell, J. H., Jefferson.  
 Campbell, J. L., Atlanta.  
 Campbell, M. G., Atlanta.  
 Campbell, W. E., Jr., Atlanta.  
 Canning, C. T., Athens.  
 Carpenter, Geo. L., Wrens.  
 Carter, R. L., Thomaston.  
 Chambers, J. A. S., Inman.  
 Champion, W. L., Atlanta.  
 Chason, Thos., Donaldsonville.  
 Cheek, O. H., Dublin.  
 Cheek, Pratt, Gainesville.  
 Childs, J. R., Atlanta.  
 Childs, LeRoy, Atlanta.  
 Clark, J. J., Atlanta.  
 Clark, M. A., Macon.  
 Clark, S. A., Eatonton.  
 Clark, T. H., Douglas.  
 Clark, W. H., LaGrange.  
 Claxton, E. B., Dublin.  
 Clay, Grady E., Atlanta.  
 Clifton, B. H., Atlanta.  
 Cline, B. McH., Atlanta.  
 Clodfelter, T. C., Tignall.  
 Cochran, J. S., Norcross.  
 Cofer, O. S., Atlanta.  
 Coile, F. W., Winterville.  
 Coker, G. N., Canton.  
 Coleman, A. S. M., Douglas.  
 Coleman, W. A., Eastman.  
 Collier, J. T., Atlanta.  
 Colvin, F. G., Thomson.  
 Colvin, E. S., Atlanta.  
 Combs, J. A., Atlanta.  
 Cook, Geo. L., Atlanta.  
 Cook, W. L., Columbus.  
 Cooper, J. J., Cedartown.  
 Corry, John A., Barnesville.  
 Copeloff, M. B., Atlanta.  
 Corn, Earnest, Macon.  
 Cousins, W. L., Atlanta.  
 Cowan, Z. S., Atlanta.  
 Cox, C. G., Milledgeville.  
 Crane, C. W., Augusta.  
 Cranston, W. J., Augusta.  
 Crichton, R. B., Atlanta.  
 Crawford, C. B., Blue Ridge.  
 Crawford, H. C., Atlanta.  
 Crawford, J. H., Atlanta.  
 Crawford, R. D., Atlanta.

**D**

Dabney, W. C., Atlanta.  
 Dancy, W. R., Savannah.  
 Daniel, E. L., Atlanta.  
 Daniel, J. C., Decatur.  
 Daniel, J. W., Savannah.  
 Davenport, F. F., Atlanta.  
 Davidson, A. A., Augusta.  
 Davis, B. B., Gainesville.  
 Davis, E. C., Atlanta.  
 Davis, W. A., Atlanta.  
 Davis, W. L., Albany.  
 Davison, Hal, Atlanta.  
 Davison, T. C., Atlanta.  
 Dean, J. G., Dawson.  
 Dellinger, A. H., Rome.  
 Denton, J. F., Atlanta.  
 Derr, John S., Atlanta.  
 Derrick, H. C., Oglethorpe.  
 DeLoach, A. G., Atlanta.  
 Dimmock, A. M., Atlanta.  
 Dorrough, W. S., Atlanta.  
 Dorsey, R. T., Atlanta.  
 Donaldson, W. R., Atlanta.  
 Douglas, W. C., Talbotton.  
 Downey, J. H., Gainesville.  
 Downman, C. E., Atlanta.  
 Duncan, B. C., Atlanta.  
 Dunn, W. N., Atlanta.  
 DuVall, W. B., Atlanta.

**E**

Earnest, J. G., Atlanta.  
 Echols, Geo. L., Milledgeville.  
 Edgerton, M. T., Atlanta.  
 Edmondson, J. W., Dublin.  
 Elder, E. B., Atlanta.  
 Elder, O. F., Atlanta.  
 Elkin, Arch, Atlanta.  
 Elkin, D. C., Atlanta.  
 Ellis, Chas., Kingston.  
 Ellis, J. N., Atlanta.  
 Elmore, B. V., Rome.  
 Elrod, J. O., Forsyth.  
 Emery, W. B., Atlanta.  
 Equen, M. S., Atlanta.  
 Erwin, H. L., Dalton.  
 Eskridge, Frank, Atlanta.  
 Estes, H. G., Atlanta.  
 Estes, J. L., Atlanta.  
 Etheridge, W. M., Atlanta.  
 Exley, H. T., Savannah.  
 Ezell, E. G., Oliver.

**F**

Faggart, G. H., Savannah.  
 Fanning, O. O., Atlanta.  
 Fincher, J. K., Atlanta.  
 Fitts, J. B., Atlanta.  
 Flick, W. A., Atlanta.  
 Floyd, Earl, Atlanta.  
 Floyd, F. F., Statesboro.  
 Floyd, J. T., Atlanta.  
 Floyd, W. B., Rome.  
 Fort, A. G., Atlanta.  
 Fort, M. A., Bainbridge.  
 Forrer, D. A., Griffin.  
 Fountain, J. A., Macon.  
 Fowler, R. W., Marietta.  
 Franklin, R. C., Swainsboro.  
 Freeman, J. F., Atlanta.  
 Freeman, Ralph, Hoschton.



Freeman, W. T., Atlanta.  
Fuller, Geo. W., Atlanta.  
Fuller, J. R., Atlanta.  
Fullilove, H. M., Athens.  
Funkhouser, W. L., Atlanta.

**G**

Garrard, J. L., Rome.  
Gary, Loren, Georgetown.  
Gaines, L. M., Atlanta.  
Gaines, T. R., Hartwell.  
Gay, B. B., Atlanta.  
Gay, Thos. Bolling, Athens.  
Gardner, W. A., Atlanta.  
Garner, J. R., Atlanta.  
Gholston, W. D., Danielsville.  
Ghesling, Goodwin, Greensboro.  
Giddings, Glennville, Atlanta.  
Gibson, Sterling, Thomson.  
Gilbert, R. B., Greenville.  
Gleaton, E. N., Savannah.  
Goldsmith, L. H., Atlanta.  
Goodwyn, H. J., Carrollton.  
Goodwyn, T. P., Atlanta.  
Goodpasture, W. C., Atlanta.  
Goldsmith, W. S., Atlanta.  
Graves, John R., Zebulon.  
Gray, J. D., Augusta.  
Green, A. J., Union City.  
Greene, E. H., Atlanta.  
Greer, C. A., Oglethorpe.  
Greer, C. B., Brunswick.  
Grove, L. W., Atlanta.  
Griffin, Claude, Carrollton.  
Grubbs, J. H., Molena.  
Guthrie, N. J., Norcross.

**H**

Hadaway, H. D., LaGrange.  
Hailey, W. H., Atlanta.  
Hailey, W. I., Hartwell.  
Hall, C. E., Atlanta.  
Hall, H. M., Cedartown.  
Hall, O. D., Atlanta.  
Hall, T. H., Macon.  
Hames, Fred, Atlanta.  
Hammond, G. W., Hoopville.  
Hammond, J. H., LaFayette.  
Harbin, W. P., Rome.  
Hardin, Sage, Atlanta.  
Hardman, L. S., Commerce.  
Harper, G. T., Dewey Rose.  
Harrell, H. P., Augusta.  
Harris, C. A., The Rock.  
Harris, E. R., Winder.  
Harris, J. C., Ridgeway.  
Harrison, D. C., Kite.  
Harrison, M. T., Atlanta.  
Harrison, W. A., Decatur.  
Harrold, C. C., Macon.  
Harvard, V. O., Arabi.  
Harvey, C. W., Hogansville.  
Head, M. M., Zebulon.  
Herman, E. C., LaGrange.  
Hiers, J. Lawton, Savannah.  
Highsmith, E. H., Atlanta.  
Hobgood, L. M., Fairburn.  
Hodges, J. H., Hapeville.  
Hodges, L. W., Winder.  
Holcombe, T. L., Union Point.  
Holland, H. C., Atlanta.  
Holliday, J. C., Athens.  
Holliday, P. L., Athens.  
Holmes, C. H., Atlanta.  
Holmes, W. R., Atlanta.  
Hoppe, L. D., Atlanta.  
Horton, A. L., Taylorsville.

Horton, B. E., Atlanta.  
Howard, P. M., Atlanta.  
Howell, C. B., Jackson.  
Hubbard, F. M., Commerce.  
Hubert, M. A., Athens.  
Huguley, G. P., Atlanta.  
Hull, M. McH., Atlanta.  
Hunter, Conway, Atlanta.  
Hutchins, W. J., Buford.

**I**

Irvin, I. W., Albany.

**J**

Jackson, Zach. W., Atlanta.  
Jenkins, W. F., Columbus.  
Jernigan, C. S., Sparta.  
Jones, A. B., Tyrone.  
Jones, B. B., Metter.  
Jones, Jack, Atlanta.  
Jones, Willis, Atlanta.  
Jones, W. T., Atlanta.  
Johnson, J. C., Atlanta.  
Johnston, J. V., Calhoun.  
Jordan, J. R., Ellaville.  
Jordan, W. P., Columbus.

**K**

Kaye, J. B., Byron.  
Kelley, D. C., Lawrenceville.  
Kelley, L. H., Atlanta.  
Kennedy, J. P., Atlanta.  
Kenyon, J. M., Richland.  
Kenyon, Steve P., Dawson.  
Kinard, J. O., Atlanta.  
King, J. Cheston, Atlanta.  
King, J. L., Macon.  
Kirby, E. G., Carrollton.  
Kirkland, S. A., Atlanta.  
Kite, J. H., Atlanta.  
Klugh, Geo. F., Atlanta.

**L**

Lake, William, Atlanta.  
Lancaster, J. M., Shady Dale.  
Landham, J. W., Atlanta.  
Lanier, L. F., Rocky Ford.  
Lawrence, C. E., Atlanta.  
Leadingham, R. S., Atlanta.  
Lewis, S. J., Augusta.  
Lewis, W. H., Rome.  
Levington, Henry, Savannah.  
Lindley, F. P., Powder Springs.  
Lipscomb, W. E., Cummings.  
Littlejohn, W. S., Rugulo.  
Lokey, H. M., Atlanta.  
Lowry, T., Cartersville.  
Luke, J. C., Ocilla.  
Lyle, W. C., Atlanta.  
Lyon, H. P., Atlanta.

**M**

Malone, G. W., Sandersville.  
Malone, W. H., Tallapoosa.  
Manget, J. D., Atlanta.  
Martin, J. J., Atlanta.  
Martin, N. M., Shellman.  
Mashburn, C. M., Atlanta.  
Mashburn, Marcus, Cummings.  
Massenburg, C. Y., Macon.  
Matthews, M. F., Athens.  
Matthews, O. H., Atlanta.  
Medlin, W. D., Summerlin.  
Meeks, D. H., Nicholas.  
Meeks, W. T., Gainesville.  
Michel, H. M., Augusta.  
Middlebrooks, J. D., Powder Springs.

Middleton, D. S., Rising Fawn.  
Miles, W. C., Griffin.  
Miller, H. C., Atlanta.  
Miller, R. L., Waynesboro.  
Minchew, B. H., Augusta.  
Mixon, W. D., Waycross.  
Mizell, G. C., Atlanta.  
Montford, J. M., Atlanta.  
Moon, P. L., Atlanta.  
Mooney, A. J., Statesboro.  
Moore, Cliff, Lindale.  
Moore, H. M., Thomasville.  
Morris, S. L., Jr., Atlanta.  
Muckenfuss, R. S., Macon.  
Mulherin, W. A., Augusta.  
Mull, J. H., Rome.  
Murphey, E. E., Augusta.  
Muse, L. H., Atlanta.

**Mc**

McArthur, T. J., Cordele.  
McAfee, L. C., Macon.  
McAiley, R. Geo., Atlanta.  
McCall, J. T., Rome.  
McCay, C. G., Atlanta.  
McCord, M. M., Rome.  
McCurdy, E. C., Shellman.  
McClintic, J. K., Monroe.  
McCoy, W. R., Atlanta.  
McCullough, K., Waycross.  
McCurry, W. E., Hartwell.  
McDougall, J. C., Atlanta.  
McDougall, W. L., Atlanta.  
McDuffie, H. H., Atlanta.  
McDuffie, J. H., Jr., Columbus.  
McGarity, J. A., Atlanta.  
McLarty, M. W., Atlanta.  
McRae, Floyd W., Atlanta.  
McMaster, D. E., Tennille.

**N**

Neagle, H. B., Augusta.  
Nellans, C. T., Atlanta.  
Nesbit, Frank, Atlanta.  
Newberry, R. E., Atlanta.  
Newman, W. A., Macon.  
Nicolson, W. P., Jr., Atlanta.  
Niles, Geo. M., Atlanta.  
Nicolson, W. P., Sr., Atlanta.  
Nolan, C. T., Marietta.  
Norton, W. A., Savannah.  
Nutt, J. J., Bowdoin.

**O**

O'Neal, Rance, West Point.  
O'Neal, R. S., LaGrange.  
Oppenheimer, R. H., Atlanta.  
Orr, J. C., Buford.  
Orr, W. L., Perry.  
Owens, W. Duncan, Atlanta.  
Owensby, N. M., Atlanta.

**P**

Page, Hugh N., Augusta.  
Paine, C. H., Atlanta.  
Palmer, J. B., Thomasville.  
Palmer, J. W., Ailey.  
Patterson, J. C., Cuthbert.  
Paulin, J. E., Atlanta.  
Peacock, C. L., Columbus.  
Peeler, J. E., Talbotton.  
Pendergrass, R. C., Atlanta.  
Pennington, C. L., Macon.  
Perkinson, W. H., Marietta.  
Person, W. E., Atlanta.  
Pettit, J. T., Canton.  
Phillips, W. P., LaGrange.

Pinson, C. H., Hapeville.  
Pirkle, W. W., Cummings.  
Pittard, L. Y., Monticello.  
Pittman, J. F., Decatur.  
Poer, J. M., West Point.  
Porter, J. L., Madison.  
Powell, Clayton, Atlanta.  
Prinrose, A. C., Americus.  
Pruitt, M. C., Atlanta.

**Q**

Quillian, G. W., Atlanta.  
Quillian, W. E., Atlanta.

**R**

Ragan, W. E., Atlanta.  
Randle, J. H., Covington.  
Rawiszer, Hubert, Atlanta.  
Rawlings, William, Sandersville.  
Rayle, A. A., Athens.  
Reavis, W. F., Waycross.  
Redd, S. C., Atlanta.  
Redfearn, J. A., Albany.  
Reed, Clinton, Atlanta.  
Reese, D. S., Carrollton.  
Reeves, T. W., Carrollton.  
Reynolds, H. L., Atlanta.  
Rhodes, C. A., Atlanta.  
Rhodes, J. A., Crawfordville.  
Richardson, C. H., Jr., Macon.  
Richardson, E. H., Cedartown.  
Ricketson, F. B., Warrenton.  
Ridgeway, G. T., Royston.  
Ridley, C. L., Macon.  
Riley, J. G., Atlanta.  
Riley, J. H., Haddock.  
Ridley, R. B., Atlanta.  
Roberts, C. W., Atlanta.  
Roberts, Hines, Atlanta.  
Roberts, J. W., Atlanta.  
Roberts, O. W., Carrollton.  
Roberts, Stewart R., Atlanta.  
Robinson, L. B., Atlanta.  
Rogers, A. A., Commerce.  
Rogers, H. A., Jeffersonville.  
Rogers, J. M., Barnesville.  
Rogers, R. L., Fairmount.  
Rogers, R. L., Gainesville.  
Rogers, Thos. E., Macon.  
Rollins, J. C., Dalton.  
Roper, L. R., Comer.  
Ronglin, L. C., Atlanta.  
Rozar, A. R., Macon.  
Rushin, C. E., Atlanta.

**S**

Sage, Dan Y., Atlanta.  
Sanders, A. S., Atlanta.  
Sauls, H. C., Atlanta.  
Sawyer, Annie, Atlanta.  
Saye, E. B., Milledgeville.  
Scales, F. S., Carrollton.  
Schneider, J. F., Atlanta.  
Scott, W. M., Deveraux.  
Selman, W. A., Atlanta.  
Shackleford, B. L., Atlanta.

Shallenberger, W. L., Atlanta.  
Shanks, E. D., Atlanta.  
Sharp, C. K., Arlington.  
Sharp, W. J., Rome.  
Shearouse, J. W., Savannah.  
Sigman, J. M., Macon.  
Simmons, J. L., Dallas.  
Simmons, W. E., Metter.  
Simpson, A. W., Washington.  
Simpson, J. R., Gainesville.  
Sims, M. R., Atlanta.  
Sinkoe, S. J., Atlanta.  
Slack, H. R., LaGrange.  
Sloan, W. P., McDonough.  
Smith, Arch, Atlanta.  
Smith, A. C., Elberton.  
Smith, E. C., Donaldsonville.  
Smith, G. B., Rome.  
Smith, J. R., Atlanta.  
Smith, Linton, Atlanta.  
Smith, W. R., Atlanta.  
Sommerfield, J. E., Atlanta.  
Stampa, S., Atlanta.  
Stephens, R. G., Atlanta.  
Stegall, P. H., Atlanta.  
Stewart, J. H., Jr., Athens.  
Stow, M. N., Jesup.  
Strickler, C. W., Atlanta.  
Styles, O. R., Carrollton.  
Suggs, C. E., Barnesville.  
Summerlin, J. A., Moultrie.  
Sutton, F. M., Atlanta.  
Swanson, Cosby, Atlanta.  
Sweet, Mary F., Decatur.  
Sydenstricker, V. P., Augusta.

**T**

Tankersley, J. S., Ellijay.  
Tatum, P. A., Columbus.  
Taylor, P. W., West Point.  
Teasley, B. C., Hartwell.  
Thomas, F. H., Valdosta.  
Thomas, J. M., Griffin.  
Thompson, C., Millen.  
Thompson, T. C., Vidalia.  
Thrash, E. C., Atlanta.  
Tippins, H. L., Savannah.  
Toepel, Theo., Atlanta.  
Tribble, J. C., Atlanta.  
Tribble, J. M., Senoia.  
Tribble, N. O., Atlanta.  
Turner, John W., Atlanta.  
Tye, R. L., McDonough.  
Tyler, L. V., Hephzibah.

**U**

Upchurch, W. A., Atlanta.  
Upshaw, C. B., Atlanta.  
Usher, Chas., Savannah.

**V**

Vansant, C. V., Douglasville.  
Vaughn, Harry, Atlanta.  
Vickers, T. E., Wrightsville.  
Vinson, C. D., Atlanta.  
Vogt, F. A., Atlanta.

**W**

Wagon, B. H., Atlanta.  
Wailes, C. E., Atlanta.  
Walker, C. H., Macon.  
Walker, Sidney, Dublin.  
Wall, C. K., Thomasville.  
Wallis, J. W., High Shoals.  
Ware, C. E., Atlanta.  
Ware, Ford, Cordele.  
Ware, F. L., Warrenton.  
Waring, A. J., Savannah.  
Warnock, R. T., Atlanta.  
Warren, W. C., Atlanta.  
Watkins, A. R., Chamblee.  
Watt, C. H., Thomasville.  
Weaver, J. Calvin, Atlanta.  
Wells, W. F., Hapeville.  
Welsh, L. L., Marietta.  
West, C. M., Atlanta.  
West, Hugh, Atlanta.  
Westmoreland, W. F., Atlanta.  
Wheat, R. F., Bainbridge.  
Whelchel, C. D., Gainesville.  
Whelchel, H. C., Douglas.  
Whiddon, L. L., Ocilla.  
White, A. F., Flovilla.  
White, John B., Atlanta.  
White, John C., Atlanta.  
White, O. T., Atlanta.  
Whitehead, W. F., Columbus.  
Whiteley, S. L., Cedartown.  
Wilcox, E. Z., Augusta.  
Williams, C. O., West Point.  
Williams, W. A., Macon.  
Willis, C. H., Barnesville.  
Wilson, B. V., Decatur.  
Wilson, Pleas, Newborn.  
Wilson, R. E., Cartersville.  
Wise, S. P., Plains.  
Wood, C. V., Cedartown.  
Wood, James, Atlanta.

**Y**

Yampolsky, J., Atlanta.  
Yankey, W. E., Atlanta.

**VISITORS**

Alexander, R. J., Texas.  
Ayers, T., Shantung, China.  
Bird, B. Cosby, Montgomery, Ala.  
Burkhead, J. D., Opelika, Ala.  
Cates, C. O., Greenville, S. C.  
Clarke, E., New York City.  
Corn, C. P., Greenville, S. C.  
Francis, Edward, Surgeon, U. S.  
P. H. S., Washington, D. C.,  
invited guest of the Association.  
Leonhertsberger, Haus, Vienna,  
Germany.  
Love, W. J., Opelika, Ala.  
Marshall, W. L., Landsdale, Ala.  
Morrow, J. S., Apalachicola, Fla.  
Sistrunk, Walter E., Mayo Clinic,  
Rochester, Minn., invited guest  
of the Association.  
Thompson, C. V., New York.

# Medical Association of Georgia

Next Annual Meeting, Albany, Ga., May 12, 13, 14, 1926

President.....	Frank K. Boland, Atlanta
First Vice-President.....	W. R. Dancy, Savannah
Second Vice-President.....	H. M. Fullilove, Athens
Delegate to A. M. A. (1925)	A. H. Bunce, Atlanta
Alternate, W. C. Lyle, Atlanta	
Secretary-Treasurer.....	Allen H. Bunce, Atlanta
Parliamentarian.....	M. A. Clark, Macon
Delegate to A. M. A. (1926)	R. L. Miller, Waynesboro
Alternate, C. W. Roberts, Atlanta	

## COUNCIL

V. O. Harvard, Chairman .....	Arabi	Allen H. Bunce, Secretary .....	Atlanta
-------------------------------	-------	---------------------------------	---------

### Councillors

1. Chas. Usher (1927).....	Savannah
2. C. K. Sharp (1927).....	Arlington
3. V. O. Harvard (1927).....	Arabi
4. O. W. Roberts (1927).....	Carrollton
5. E. C. Thrash (1928).....	Atlanta
6. M. M. Head (1928).....	Zebulon
7. M. M. McCord (1928).....	Rome
8. Stewart D. Brown (1928).....	Royston
9. C. D. Whelchel (1926).....	Gainesville
10. S. J. Lewis (1926).....	Augusta
11. A. S. M. Coleman (1926).....	Douglas
12. T. C. Thompson (1926).....	Vidalia

### Vice-Councillors

1. C. Thompson (1927).....	Millen
2. R. F. Wheat (1927).....	Bainbridge
3. J. F. Lunsford (1927).....	Preston
4. J. A. Thrash (1927).....	Columbus
5. W. A. Selman (1928).....	Atlanta
6. J. M. Anderson (1928).....	Barnesville
7. J. H. Hammond (1928).....	LaFayette
8. B. C. Teasley (1928).....	Hartwell
9. W. J. Hutchins (1926).....	Buford
10. H. D. Allen, Jr. (1926).....	Milledgeville
11. K. McCullough (1926).....	Waycross
12. J. Cox Wall (1926).....	Eastman

## COMMITTEES

### Committee on Scientific Work

W. A. Mulherin, Chairman (1926).....	Augusta
Frank Bird (1926).....	Valdosta
A. H. Bunce, Secretary-Treasurer.....	Atlanta

### Committee on Public Policy and Legislation

J. W. Palmer, Chairman (1926).....	Ailey
W. E. McCurry (1927).....	Hartwell
B. H. Wagnon (1928).....	Atlanta
Frank K. Boland, President.....	Atlanta
Allen H. Bunce, Secretary-Treasurer.....	Atlanta

### Committee on Medical Defense

M. A. Clark, Chairman (1928).....	Macon
E. C. Thrash (1926).....	Atlanta
E. C. Davis (1929).....	Atlanta
V. O. Harvard, Chairman, Council.....	Arabi
Allen H. Bunce, Secretary-Treasurer.....	Atlanta

### Committee on Hospitals

C. Thompson, Chairman (1926).....	Millen
R. M. Harbin (1926).....	Rome
W. H. Myers (1926).....	Savannah

### Committee on Necrology

E. R. Anthony, Sr., Chairman (1926).....	Griffin
L. A. Baker (1926).....	Tifton
W. H. Clark (1926).....	LaGrange

### Committee on Health and Public Instruction

Theo. Toepel, Chairman (1926).....	Atlanta
H. B. Neagle (1928).....	Augusta
J. A. Thrash (1927).....	Columbus
Frank K. Boland, President.....	Atlanta
Allen H. Bunce, Secretary-Treasurer.....	Atlanta

### Cancer Commission

J. L. Campbell, Chairman.....	Atlanta
Chas. Usher.....	Savannah
C. H. Watt.....	Thomasville
G. Y. Moore.....	Cuthbert
Frank P. Norman.....	Columbus
A. R. Rozar.....	Macon
W. H. Lewis.....	Rome
J. S. Stewart, Jr.....	Athens
M. B. Allen.....	Hoschton
E. A. Wilcox.....	Augusta
H. M. Branham.....	Brunswick
T. C. Thompson.....	Vidalia

### Committee on National Defense

1. R. E. Graham.....	Savannah
2. H. M. Moore.....	Thomasville
3. Job. C. Patterson.....	Cuthbert
4. W. F. Jenkins.....	Columbus
5. R. R. Daly, Chairman.....	Atlanta
6. Linwood M. Gable.....	Griffin
7. Chas. V. Wood.....	Cedartown
8. Eugene F. Griffith.....	Eatonton
9. John K. Burns.....	Gainesville
10. Francis X. Mulherin.....	Augusta
11. G. T. Crozier.....	Valdosta
12. Ovid H. Cheek.....	Dublin

### Fraternal Delegates to Other State Meetings

To Visit Florida: B. H. Minchew, Waycross;
Geo. L. Touchton, Savannah.
To Visit South Carolina: E. E. Murphey, Augusta;
B. C. Teasley, Hartwell.
To Visit Alabama: J. M. Anderson, Columbus;
J. W. Landham, Atlanta.
To Visit Tennessee: H. L. Erwin, Dalton; J. H.
Hammond, LaFayette.
To Visit North Carolina: J. H. Downey, Gaines-
ville; C. L. Ayers, Toccoa.



## STATE BOARD OF MEDICAL EXAMINERS

J. W. Palmer, M.D., President, Ailey.  
 W. C. Williams, Jr., M.D., Vice-President, Cochran.  
 L. A. Baker, M.D., Tifton.  
 C. T. Nolan, M.D., Sec.-Treas., Marietta.  
 H. F. McDuffie, M.D., Atlanta.

O. B. Walker, M.D., Bowman.  
 H. G. Maxey, M.D., Maxeys.  
 A. F. White, M.D., Flovilla.  
 C. M. Paine, M.D., Atlanta.  
 B. T. Wise, M.D., Plains.

Georgia reciprocates with the states named below on the basis of a diploma only if the applicant had his diploma registered prior to December, 1894. After this date applicants who desire to get Georgia license through reciprocity are required to have stood State Board Examination. After April, 1914, applicants must not have graduated from class C colleges. Georgia does not require that applicants should have practiced one year or any other length of time in the State where they received their license before they will be eligible for reciprocity. Applicants for a certificate on the basis of reciprocity must make formal application on a blank provided by the State Board of Examiners. This blank can be secured by writing to the Secretary of this Board. The fee for reciprocity is \$50.00. The fee for certifying to Georgia License of those leaving the State for reciprocity with another State is \$10.00. The State Board examinations are held in June of each year in Atlanta and Augusta and on the second Tuesday in October of each year in Atlanta in the Legislative Hall of the State Capitol.

### STATES WITH WHICH GEORGIA RECIPROCATES

Alabama	Iowa	Minnesota	New Jersey	Texas
Arkansas	Kentucky	Mississippi	North Carolina	Utah
Colorado	Kansas	Michigan	Oklahoma	Vermont
California	Louisiana	Missouri	Pennsylvania	Virginia
Dist. of Columbia	Maine	Nebraska	South Carolina	Washington State
Indiana	Maryland	New Hampshire	Tennessee	West Virginia

## GEORGIA STATE BOARD OF HEALTH

Dr. John W. Daniel, Savannah.  
 Dr. A. D. Little, Thomasville.  
 Dr. F. D. Patterson, Cuthbert.  
 Dr. J. H. McDuffie, Vice-President, Columbus.  
 Mr. Robert F. Maddox, President, Atlanta.  
 Dr. Chas. H. Richardson, Macon.  
 Dr. A. C. Shamblin, Rome.  
 Dr. W. I. Hailey, Hartwell.  
 C. R. Brice, D.D.S., Gainesville.  
 Dr. John A. Rhodes, Crawfordville.  
 A. A. Lowry, D.D.S., Valdosta.  
 Dr. M. S. Brown, Fort Valley.  
 Mr. Fort E. Land, State Superintendent of Schools, ex-officio, Atlanta.  
 Dr. Peter F. Bahnsen, State Veterinarian, ex-officio, Atlanta.

Dr. T. F. Abercrombie, Secretary, ex-officio, Atlanta.

### Directors of Divisions, Georgia State Board of Health

Dr. T. F. Abercrombie, Commissioner of Health and Secretary, Atlanta.  
 Dr. Joe P. Bowdoin, Division of Venereal Disease Control and Division of Child Hygiene, Atlanta.  
 (Position Vacant at Present), Division of County Health Work, Atlanta.  
 (Position Vacant at Present), Director Malaria Control, Atlanta.  
 T. F. Sellers, Division of Laboratories, Atlanta.  
 H. C. Woodfall, Division of Sanitary Engineering and Water Analysis, Atlanta.  
 Dr. Edson W. Glidden, Superintendent State Tuberculosis Sanatorium, Alto.  
 Dr. R. W. Todd, Superintendent Georgia Training School for Mental Defectives, Gracewood.

### COMMISSIONERS OF HEALTH (Ellis Health Law)

Dr. Sam A. Anderson, Baldwin County, Milledgeville.  
 Dr. J. D. Applewhite, Clarke County, Athens.  
 Dr. L. L. Welch, Cobb County, Marietta.  
 Dr. M. A. Fort, Decatur, Seminole and Baker Counties, Bainbridge.  
 Dr. Howard E. Felton, Bartow County, Cartersville.  
 Dr. Hugo Robinson, Dougherty County, Albany.  
 Dr. B. V. Elmore, Floyd County, Rome.  
 Dr. H. L. Akridge, Glynn County, Brunswick.  
 Dr. B. D. Blackwelder, Hall County, Gainesville.  
 Dr. O. H. Cheek, Laurens County, Dublin.  
 Dr. J. H. Hammond, Walker County, LaFayette.  
 Dr. G. T. Crozier, Lowndes County, Valdosta.  
 Dr. J. W. Payne, Sumter County, Americus.  
 Dr. M. E. Winchester, Thomas County, Thomasville.  
 Dr. C. S. Kinzer, Troup County, LaGrange.  
 Dr. C. O. Rainey, Mitchell County, Camilla.  
 Dr. Geo. E. Atwood, Ware County, Waycross.

### BUREAU OF VITAL STATISTICS

Dr. T. F. Abercrombie, Secretary and State Registrar

Dr. W. A. Davis, Director

# Constituent County Societies 1925

SOCIETY	PRESIDENT	SECRETARY
Altamaha.....	(Not reported for 1925).....	
Baldwin.....	N. P. Walker, Milledgeville.....	H. D. Allen, Jr., Milledgeville
Banks.....	(Officers not reported for 1925).....	
Barrow.....	(Officers not reported for 1925).....	
Bartow.....	T. Lowry, Cartersville.....	W. E. Wofford, Cartersville
Ben Hill.....	W. P. Coffee, Fitzgerald.....	L. S. Osborne, Fitzgerald
Berrien-Lanier.....	(Not reported for 1925).....	
Bibb.....	Benj. Bashinski, Macon.....	H. G. Weaver, Macon
Blue Ridge (Fan- nin, Gilmer and Union Counties).....	J. M. Daves, Blue Ridge.....	C. B. Crawford, Blue Ridge
Bulloch-Candler.....	A. Temples, Statesboro.....	F. F. Floyd, Statesboro
Burke.....	W. R. Lowe, Midville.....	J. B. Lewis, Waynesboro
Butts.....	A. F. White, Flovilla.....	J. Lee Byron, Jackson
Brooks.....	(Not reported for 1925).....	
Campbell.....	T. J. Buscy, Fayetteville.....	A. J. Green, Union City
Carroll.....	O. R. Styles, Bowdon.....	C. C. Pitts, Carrollton
Chatham.....	J. K. Train, Savannah.....	A. A. Morrison, Savannah
Chattooga.....	R. E. Talley, Trion.....	W. B. Hair, Summerville
Cherokee.....	J. M. Bates, Canton.....	Geo. C. Brooke, Canton
Clarke.....	H. I. Reynolds, Athens.....	Thos. Bolling Gay, Athens
Cook.....	H. W. Clements, Adel.....	L. R. Hutchinson, Adel
Clayton-Fayette.....	G. W. Wallis, Fayetteville.....	H. D. Kemper, Jonesboro
Cobb.....	W. H. Perkinson, Marietta.....	R. W. Fowler, Marietta
Coffee.....	G. M. Ricketson, Broxton.....	T. H. Clark, Douglas
Colquitt.....	J. A. Summerlin, Hartsfield.....	M. H. Stuart, Moultrie
Coweta.....	(Officers not reported for 1925).....	
Crisp.....	T. E. Bradley, Cordele.....	Byron Daniel, Cordele
Decatur-Seminole.....	S. A. V. Christophine, Attapulgus.....	L. W. Willis, Bainbridge
DeKalb.....	Mary F. Sweet, Decatur.....	J. F. Pitman, Decatur
Dooly.....	R. H. Pate, Unadilla.....	F. E. Williams, Vienna
Douglas.....	C. V. Vansant, Douglasville.....	D. Houseworth, Douglasville
Dougherty.....	I. W. Irvin, Albany.....	J. A. Redfearn, Albany
Elbert.....	D. V. Bailey, Elberton.....	J. C. Hudgens, Elberton
Emanuel.....	J. D. Bailey, Summertown.....	S. S. Youmans, Oak Park
Evans.....	B. E. Miller, Claxton.....	D. S. Clanton, Hagan
Floyd.....	R. O. Rimmoms, Rome.....	J. H. Mull, Rome
Fulton.....	Theo. Toepel, Atlanta.....	Grady E. Clay, Atlanta
Forsyth.....	W. E. Lipscomb, Cummings.....	Marcus Mashburn, Cummings
Franklin.....	Stewart D. Brown, Royston.....	B. T. Smith, Carnesville
Glynn.....	John A. Dunwoody, Brunswick.....	J. P. Harrell, Brunswick
Gordon.....	M. A. Aerce, Calhoun.....	R. B. Chastain, Calhoun
Grady.....	J. B. Warnell, Cairo.....	J. V. Rogers, Cairo
Greene.....		Goodwin Ghesling, Greensboro
Gwinnett.....	W. J. Hutchins, Buford.....	N. J. Guthrie, Norcross
Habersham.....	W. V. Chandler, Baldwin.....	R. B. Lamb, Demorest
Hancock.....	C. S. Jernigan, Sparta (only member).....	
Hall.....	R. L. Rogers, Gainesville.....	Pratt Cheek, Gainesville
Haralson.....	W. H. Malone, Tallapoosa (only member).....	
Hart.....	T. R. Gaines, Hartwell.....	W. E. McCurry, Hartwell
Henry.....	R. L. Crawford, Locust Grove.....	W. P. Sloan, McDonough
Houston.....	Wm. L. Orr, Perry (only member).....	
Irwin.....	G. W. Willis, Ocilla.....	L. L. Whiddon, Ocilla
Jackson.....	O. E. Shankle, Commerce.....	J. C. Bennett, Jefferson
Jasper.....	L. Y. Pittard, Monticello.....	E. M. Lancaster, Shady Dale
Jenkins.....	M. E. Perkins, Millen.....	C. Thompson, Millen
Jones.....	J. H. Riley, Haddock.....	P. R. Chambliss, Gray
Johnson.....	T. L. Harris, Wrightsville.....	J. G. Brantley, Wrightsville
Lamar.....	C. E. Suggs, Barnesville.....	John M. Anderson, Barnesville
Laurens.....	J. E. New, Dexter.....	O. H. Cheek, Dublin
Lowndes.....	A. G. Little, Valdosta.....	Jos. A. Thomas, Valdosta
Madison.....	H. H. Hampton, Colbert.....	W. D. Gholston, Danielsville
Macon-Taylor.....	C. A. Greer, Oglethorpe.....	F. M. Mullino, Montezuma
Meriwether.....	J. A. Johnson, Manchester.....	R. B. Gilbert, Greenville
Mitchell.....	O. G. Crawford, Sale City.....	D. P. Luke, Camilla
Monroe.....	B. L. Smith, Forsyth.....	W. J. Smith, Juliette
Montgomery.....	J. W. Palmer, Ailey (only member).....	
Morgan.....	W. M. Fambrough, Bostwick.....	D. M. Carter, Madison
Murray.....	R. H. Bradley, Chatsworth.....	J. E. Bradford, Spring Place
Muscogee.....	W. P. Jordan, Columbus.....	F. B. Blackmar, Columbus
McDuffie.....	Sterling Gibson, Thomson.....	F. C. Colvin, Thomson
Newton.....		W. D. Travis, Covington
Ocmulgee (Dodge, Bleckley and Pulaski Counties).....	W. A. Mathews, Hawkinsville.....	W. H. Pirkle, Cochran
Paulding.....		
Pickens.....	H. G. Atherton, Jasper (only member).....	
Pike.....		M. M. Head, Zebulon
Polk.....	S. L. Whitely, Cedartown.....	John W. Good, Cedartown
Putnam.....	V. H. Taliaferro, Eatonton.....	S. A. Clark, Eatonton
Randolph.....	W. W. Crook, Cuthbert.....	G. Y. Moore, Cuthbert
Richmond.....	W. J. Cranston, Augusta.....	M. P. Agee, Augusta
Screven.....	W. R. Lovett, Sylvania.....	A. B. Reddick, Sylvania
		(Treas.) L. F. Lanier, Rocky Ford

## Constituent County Societies (Continued)

Stephens.....	W. M. Fresh, Toceoa.....	C. L. Ayers, Toceoa
Spalding.....	K. S. Hunt, Griffin.....	T. I. Hawkins, Griffin
Stewart-Webster.....	G. G. Lunsford, Weston.....	M. Walton, Lumpkin
Sumter.....	Kenneth Wood, Leslie.....	E. B. Anderson, Americus
Taliaferro.....	John A. Rhodes, Crawfordville.....	Alex H. Beazley, Crawfordville
Tatnall.....	J. M. Hughes, Glennville.....	Pat H. Smith, Glennville
Talbot.....		C. C. Carson, Talbotton
Telfair.....	Frank Mann, Lumber City.....	C. J. Maloy, Helena
Terrell.....	J. T. Arnold, Parrott.....	Logan Thomas, Dawson
Thomas.....	S. L. Cheshire, Thomasville.....	C. K. Wall, Thomasville
Tift.....	J. M. Price, Tifton.....	W. T. Smith, Tifton
Toombs.....	J. E. Mercer, Vidalia.....	W. W. Odom, Lyons
Turner.....	H. M. Belflower, Sycamore.....	J. H. Baxter, Ashburn
Tri (Early, Miller and Calhoun Counties).....	C. J. Jenkins, Edison.....	C. K. Sharp, Arlington
Troup.....	B. C. Daniel, LaGrange.....	R. S. O'Neal, LaGrange
Trentlein.....	L. I. Lanier, Soperton (only member).....	
Twiggs.....	T. S. Jones, Jeffersonville.....	H. A. Rogers, Jeffersonville
Upson.....	R. L. Carter, Thomaston.....	B. C. Adams, Thomaston
Walker.....	W. W. Spearman, Chickamauga.....	J. H. Hammond, LaFayette
Walton.....	H. L. Upshaw, Social Circle.....	J. K. McClintic, Monroe
Ware.....	Kenneth McCullough, Waycross.....	J. E. Penland, Waycross
Warren.....	H. L. Earl, Jewell.....	A. W. Davis, Warrenton
Wayne.....	A. J. Gordon, Jesup.....	J. T. Colvin, Jesup
Washington.....	T. B. King, Sandersville.....	N. Overby, Sandersville
Whitfield.....	Trammell Starr, Dalton.....	B. L. Kennedy, Dalton
Wilkes.....		O. S. Wood, Washington
Worth.....	J. L. Tracy, Sylvester.....	W. C. Tipton, Sylvester

### WANTED—POSITION BY NURSE

Graduate, registered nurse desires position in doctor's or dentist's office as assistant. Can furnish best of references. For further information, address, "Graduate Nurse," care Journal Medical Association of Ga., 65 Forrest Ave., Atlanta.

### FOR SALE AT BARGAIN!

Well established office practice in Atlanta. Completely equipped with numerous electro-therapeutic machines and other apparatus so necessary these days for the up-to-date physician. Will sell outfit for less than cost, introduce purchaser to good business and charge nothing for the practice turned over to him. I want to retire. Practiced long enough. Address reply to Dr. S., care this Journal.

### WANTED—LOCATION

Young doctor, graduate of Medical Department of the University of Georgia, desires location. Has just completed a year's internship in a private hospital at Macon. Address, "Location," care Journal Medical Association of Ga.

### WANTED—LOCATION

A Minnesota doctor, graduate of the McGill University, Montreal, wishes to locate in Georgia. If you know of any desirable location, please write us, care W. D. M., Journal Medical Association of Ga.

### SITUATIONS WANTED

WANTED: Salaried Appointments for Class A physicians in all branches of the Medical Profession. Let us put you in touch with the best man for your opening. Our nation-wide connections enable us to give superior service. Aznoe's National Physicians', Member The Chicago Association of Commerce.

### THE LINDORME TRUSS

The success of the Lindorme Spring Wire Truss is due to the detailed accuracy with which each is made and fitted to the individual case.

No stock Trusses kept on hand. Correspondence with Physicians invited.

A. H. LINDORME, M. D.

Suite Nos. 25-26-27

Physicians Bldg.

41 Forrest Ave., Atlanta, Ga.

Phone Connections.



# AWTRY & LOWNDES COMPANY

17 W. Cain St., Atlanta, Ga.

## PROMPT AMBULANCE SERVICE

Phone - Ivy 5613 & 5614

# STOVAR SOL

(REG. U. S. PATENT OFFICE)

Acetylamino-oxyphenylarsonic Acid

## Indicated in Amebic Dysentery

*Accepted by Council of Pharmacy and Chemistry A. M. A.*

Distributed in bottles of 25 tablets, each tablet 0.25 grams

May be obtained through your druggist

---

*Literature furnished on request*

---

MANUFACTURED BY

**POWERS-WEIGHTMAN-ROSENGARTEN CO.**

New York

PHILADELPHIA

St. Louis

# THE JOURNAL

## OF THE

# MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL PROFESSION OF GEORGIA

PUBLISHED MONTHLY under direction of the Council

Volume XIV

Atlanta, Ga., August, 1925

No. 8

## Original Articles

### THE IRRITABLE BLADDER\*

Wallace L. Bazemore, M.D.

Macon, Ga.

In a paper of this sort my remarks of necessity will be quite rambling. To begin with let me insist that cystitis in the male is not a distinct entity, but a symptom of some pathologic condition of the urinary tract. Pus and blood in the urine and disturbances of the function of micturation are definite signs of a pathologic condition that demands serious consideration. The sooner we learn the importance of accurate diagnosis in these cases, the sooner will we realize that calculi, obstructions, tumors, infections, and malformations of the urogenital tract, as well as infections of the upper urinary tract are not mendable to bladder lavage and urinary antiseptics. The offending organ may have little or no localizing symptoms, while the bladder attracts our sole attention.

The kidney may be the organ at fault, constantly feeding the bladder with infected urine. The most common kidney causes are tuberculosis, pyelonephritis, and kidneys harboring stones.

The ureter may offend either by stone, stricture or neoplastic growths. The urethra and its adnexa, is, I suppose, the most common factor in bladder irritability. The gonococcus is surely the most common offending organism. With an irritable bladder we are always faced with the possibility of stones, tumors or diverticuli within the bladder itself.

It is not within the scope of this paper to consider the medical aspects of bladder symptoms.

To return to the tubercular kidney as the offending organ: According to Brash, over ninety per cent of patients with renal tuberculosis have vesical symptoms extending over a period of six months and more than fifty per cent over a period of a year or longer. Unfortunately, the vesical symptoms in renal tuberculosis have not obtained general recognition. Reviewing some fifty-odd cases that I had the opportunity to observe at Bellevue, ninety-four per cent gave a history of vesical irritability ranging over a period of from one month to eight years. Not a single case was free of some bladder symptoms at one time or the other. The frequency varied from every few hours, day and night, to every few minutes. Sixty-five per cent of the cases voided more times by day than by night. One patient had no apparent frequency by day, but blood stained urine, while at night, he voided five or six times with no blood. It is stated that the vesical symptoms are more pronounced in man than in woman, also hematuria is more often observed in the male. Occasionally hematuria precedes irritability. Frequency, dysuria, and pyuria, and eventually hematuria are the common and universal symptoms. Thirty-nine per cent of the Bellevue cases complained of frequency, sixty-three per cent of frequency and dysuria. Only four of some fifty cases complained of hematuria alone. I think all cases of persistent irritability of the bladder, with suspicious urinary findings, should be suspected of being tubercular until proved otherwise.

Early recognition, which is most often suspected from bladder symptoms, not only gives a better prognosis, but partly prevents the deep-seated bladder infection which is at

\*Read before the Sixth District Medical Society, December 3, 1924, Macon, Ga.

times quite persistent even after the kidney is removed.

With increasing secondary infection the chances of finding the bacillus of Koch diminish. Only catheterized specimens are worth while. The ureteral catheter alone determines the offending kidney, or both. As thorough and painstaking examination should be made on one kidney as its fellow. Urine obtained from one kidney showing pus and blood while the opposite shows microscopically clear urine is good evidence that the disease is unilateral. When a few pus and blood cells are recovered from both sides it is well to suspect bilateral involvement. According to Beer, fully twenty per cent of tubercular kidneys are bilateral when they reach the surgeon's hands. The most opportune time to search for the bacillus, when it is suspected, is immediately following the pyelogram. They can be found at this time when you have failed many times before. Caspri found the organism in seventy-five per cent of his cases. At Bellevue we were not able to reach quite such a percentage. The cystoscope is many times helpful in finding bladder tubercles which are usually localized about the ureteral orifice from the affected kidney, but I have seen them more adjacent to the ureter that could not be proved tubercular. Young (1) lays stress on the bridged ureteral orifice. I have had occasion to observe two bridged ureteral orifices, both of which were in tubercular kidneys. The same observer makes mention of shortening of the ureter resulting in traction on and marked elevation of the trigone, with invagination of the ureteral ridge into the ureter.

Tubercular bladders are so irritable that successful cystoscopy must be done under some sort of anaesthesia. I prefer sacral. Their capacity, without anaesthesia, is so small that satisfactory views are not obtainable.

All cases of genital tuberculosis with pus in the urine should be cystoscoped and ureteral catheterization done. This is the only way to get these cases before bilateral renal involvement has taken place.

Pyelograms of kidneys that you are unable to demonstrate the tubercular bacillus are often helpful. The caseous foci are cov-

ered with calcium deposits and the shadows are rather characteristic. Brash (2) classifies three general radiographic types:

First, of the caseated kidney, entirely or in part.

Second, single irregular shadows of varying size outlining the caseated center of tubercular foci, which is the usual type.

Third, he recognizes the multiple, small, irregular shadows scattered over the kidney area. He also points out that not all caseated areas throw shadows. Ureterograms usually show constrictions and dilatations.

With the second most common offending kidney lesion, namely, pyelonephritis, we find a variable degree of bladder infection, usually less severe than that arising from tuberculosis with relatively less vesical symptoms. It is also true that there is less localizing kidney symptoms than with renal tuberculosis. It is the bladder irritability that suggests urinary foci. Aside from the bladder symptoms we find practically no subjective symptoms though the patient may clearly be septic and complain of only mild loin or abdominal pain. The bladder symptoms are painful and frequent urinations, but more intermittent than with tubercular lesions. There is usually considerable pus and bacteria in the urine. The degree of kidney activity may suggest any one of several conditions. Keyes (3) thinks that those cases that are too severe to be called pyelitis, too mild to be called acute bacterial nephritis without sufficient distention to be called pyonephrosis, and not due to urethral retention are relatively rare if we rule out those cases dependent upon stone in the pelvis.

In considering focal suppurative nephritis: The bladder symptoms are more severe but may be intermittent. During the most septic times the urine may be perfectly free from pus and bacteria, a condition which we account for by supposing a complete anuria from the affected kidney. During these periods of clear urine we have no lead except possibly some kidney tenderness.

Pyelographic data is of considerable help in pyelonephritis. There is a dilatation of the pelvis and ureter, the result of cicatricial changes. Such a demonstration is evidence of previous infection if the urine is clear and



shows no evidence of active infection at that time. A pyelogram may also be of help in determining if the infection is largely in the pelvis or the parenchyma. This condition is also characterized by considerable diminution in the phenol-sulphone-phthalein output as shown by Geraghty.

To return to calculi: The most pronounced bladder irritability is coincident with the attack of colic. At this time this point is most helpful in the differential diagnosis. Ureteral stones near the vesical end present more persistent vesical symptoms than those at a high level. This constant irritability and bladder pain is secondary to the inflammatory reaction resulting from the ulceration caused by the stone. The radiation of pain in renal calculi is often referred to the bladder. Many large stones completely filling the pelvis cause comparatively no symptoms even with mild infection. Roughly, one out of twenty-five cases present bilateral involvement. In such cases it is usually better to remove the stone from the best kidney first, although this cannot be put down as a hard and fast rule. With ureteral stones many methods have been used to facilitate their passage or removal. Many such stones will voluntarily pass to the bladder during an attack of colic. Others will not pass and will threaten the kidney with destruction, and it is in this type that instrumentation is advised. By employing catheters and other ureteral instruments many stones can be made to pass by non-operative measures. It should always be given a preference before operation. How often and how many times this procedure should be carried out cannot be said. It varies with the progress and each individual. I have more than once released stones from the vesical ureter by meatotomy, or by fulguration. There are some contra-indications to such procedures, of which may be recalled patients with an intolerance to the cystoscope with stones that are too large and in renal infections.

More radical procedures should be employed in these cases.

Accurate diagnosis can be depended upon in most cases by combining the X-ray with the Opaque catheter plus ureterograms and in some cases the wax-tip catheter is helpful.

The stone having passed to the bladder it is considered as such. It is not always an easy matter to satisfy one's mind as to the origin of vesical calculi. They are either primary or secondary; that is, ureteral in origin or one that forms within the bladder. A few stones form around foreign bodies that are introduced into the bladder. It is always necessary to question such a patient regarding previous renal colic, in as much as they see no connection between a loin pain some years previously and his present trouble. In the United States we see comparatively few bladder stones in childhood. Crenshaw, (4) analyzing six hundred and six cases of vesical calculi, reports the average age at 55.59. Fifteen cases had ureteral-bladder stones, thirteen of which were in men and two in women. This same observer reports that out of the six hundred and six cases, two hundred and seventy-seven had prostatic obstruction and forty-five had stricture of the urethra, or seventy per cent with urethral obstruction. In five per cent diverticuli were present. Fifteen cases had stone and tumor.

The fact is pointed out that in spite of the severe cystitis, chills and fever were present in a very small percentage, and in this small group pyelonephritis was present in over three-fourths of the cases. This low percentage, along with the low percentage of metastasis in bladder tumors, impresses us with the fact that the bladder is relatively poor in lymphatics. When chills and sweats intervene in bladder stone cases we should suspect extension of the infection to other organs.

The bladder that harbors stones is intensely sensitive. The frequency and pain is usually intense, being less painful at nights or when the patient is recumbent. Urination is at times as often as every ten minutes. Such fits are not lasting. Hematuria is rare at first, while later on as the stone attains considerable size it is more constant. The sudden stoppage of urine so often spoken of is rare.

Combined cystoscopy and X-ray makes the diagnosis in more than ninety-five per cent of the cases. Neither is infallible. Even large stones are sometimes missed by both.

Diverticuli in uninflamed bladders are symptomless. When once infected it presents a stubborn case of cystitis. They quite often harbor stones. A few have difficulty of urination, while others void unusual quantities at times.

Tumors of the bladder are usually suspected first by hemorrhage. A spontaneous profuse hemorrhage uninfluenced by rest is most characteristic of neoplasm, whether it be renal or vesical. Retention is usually secondary to clots rather than to the tumor mass itself. Painful urination is a later symptom, due either to retention, the passage of clots, or extensive infiltration. The cystitis of bladder tumors is usually ammoniacal and leads to incrustation.

We see a few cases with extra-vesical growths, which primarily complain of vesical irritability. I recently observed such a case. At cystoscopy there was definitely extravescic pressure. This case came to me complaining of frequency and pelvic pain. A hysterectomy cured her, a large uterine tumor being present.

I will not burden you with the detailed enumeration of the many prostatic and urethral conditions that show themselves either solely or in part by vesical irritability. We may mention as the most important, genital tuberculosis and various prostatic and seminal vesical infections, urethral caruncles, cysts and papillomata about the montane region with the so common posterior urethral infections. Cysto-urethroscope is helpful in making a diagnosis in cases of this sort.

Prostatic cases are certainly in the vast majority of times ushered in with bladder symptoms. A negative rectal examination does not exclude a middle lobe or a contraction of the bladder neck. The cystoscope alone makes the diagnosis. We should always be alert to spinal cord diseases in undiagnosed bladder cases. They usually begin with retention which leads to incontinence, although they may begin just the opposite. The incontinence is not an overflow as in prostatic hypertrophy, and a catheter passed in such cases, revealing no residual urine should at once put us on our guard.

Lastly, I shall consider a condition that has only recently been brought before us and one that presents fairly characteristic findings, but which at times is most evading, namely, Hunner's ulcer (5). This rare form of bladder ulcer is known under the name of submucous ulcer, interstitial cystitis, paracystitis and elusive ulcer. This condition only slightly involves the mucosa in contradistinction to the simple ulcers of the bladder which do attack the mucosa and to a varying degree.

It has only of late been found in the male, it being much more prevalent in the female. No definite reason has been given for this.

Marked agonizing symptoms may be present with practically clear urine. Most cases have only a few pus and blood cells present. Intermittent hematuria, pain and frequency with practically negative urine should lead us to suspect this condition. Bumpus, in his series of cases, points out that the average duration of symptoms was ten years. Focal infection is thought to play a part as the causative factor.

These bladders are highly sensitive when even a few ounces of urine accumulate. There is marked suprapubic pain. Cystoscopy is difficult for this reason but on it alone can we rely for a diagnosis.

A few cases are helped by topical applications, a few by fulguration, more by wide bladder resection, while there is a certain per cent that remains unhelped after all is tried.

Thus we see the many conditions that are ushered in or that stand out complaining of bladder symptoms. To add the medical conditions would only more confuse us.

#### REFERENCES

1. Young, Hugh Hampton: Changes in the Trigone due to Tuberculosis of the Kidney, Ureter and Bladder. Bridged formation and floating Trigone. *Surgery, Gynecology and Obstetrics*. June, 1918, pp. 608-615.
2. Braasch, W. F.: Clinical observations from 203 patients operated on for Renal Tuberculosis. Reprint from the *Journal of the American Medical Association*, pp. 7-9-18. Feb. 10, 1912.
3. Keyes, Edward L. Non-Tubercular Renal Infections. Reprint from the *Boston Medical and Surgical Journal*, Vol. CLXII, No. 10, pp. 307-313. March 10, 1910.
4. Crenshaw, John L.: Vesical Calculus. *The Journal of the American Medical Association*, Vol. 77, pp. 1071. Oct. 1921.
5. Bumpus, Herman C.: Submucous ulcer of the bladder in the male. *The Journal of Urology*. Vol. 5. No. 3. March, 1921.



## REPORT OF 2,000 INFANTS FED ON DRY MILK\*

Mather M. McCord, M.D., Rome, Ga.

Possibly there are some doctors who have had very little if any experience with dry milk. Before going into any actual case reports, therefore, I shall attempt to explain it.

Dry milk is a powdered form of fresh cow's milk obtained by evaporation of the water. It is dried while it flows over hot revolving cylinders, and in the dry state contains all of the original elements except water and a small portion of the fats. This reduction in fats seems to me an advantage, because during the first year of life and the weaning period, when dry milk is of the greatest value, there is no need for high fats in milk. In fact, most of the trouble infants have, aside from contaminated milk, and condensed milk too high in cane sugar, causing sugar indigestion, is taking raw cow's milk too high in fats, causing fatty indigestion. This powder is put up in cans immediately after giving up its water, and can be at once prepared for feeding purposes by dissolving in hot water. It has nothing in it, not even a preservative.

In speaking on this subject Hill says: "Dried milk undoubtedly has a definite place in infant feeding. It has come to stay. It should be a godsend to the South in the summer."

In this connection Naish also says: "I have followed up a considerable number of infants fed on dry milk, and I am personally convinced that there is no more risk of rickets with this diet than with a good quality of raw cow's milk." He also states that it is possible to cure rickets by changing a previously given diet to a dry milk diet.

I now quote Millard: "It was soon discovered, however, that dry milk had one most important advantage—greater digestibility—and that many infants would retain it and at once begin to thrive, who previously had been continuously subject to vomiting after each feeding, and in consequence were making little or no progress. A careful watch has been kept for any bad effects, such as scurvy or rickets, but although I have had experi-

ence of some hundreds of infants fed on it for periods ranging up to ten months, or even longer, so far none have been found. Inquiries also have been made from fifteen medical men practicing in the districts from whence most of the cases have been drawn, and their replies in all cases were most favorable to the use of dry milk, and support the conclusions that no bad effects followed."

Regarding the feeding of prematures with dry milk, Fischer says: "This dry powder contains four calories to the teaspoonful, and is soluble in hot water. It is readily taken by infants. Dryco does not contain sugar, and where there is a low sugar tolerance or low starch tolerance, then dry milk is an excellent food. It is readily taken by the older child and equally as well taken by the premature infant without causing gastro-intestinal derangements. In a series of premature infants and cases of malnutrition treated at the infanatorium, in which even the weakest milk mixtures such as whey and buttermilk whey were not tolerated, Dryco was retained and well assimilated."

Surely the feeding of prematures is one of the severest tests to which any form of milk could be put. If it has proved a good food in such extreme cases of feeding, no better proof should be desired to convince one of its efficiency in all cases where a safe milk of high nutritive value is desired. My paper today only emphasizes the value of dry milk for infant feeding. But in older children and even adults where a safe milk is desired in such conditions as malnutrition, prompt results have followed the use of dry milk. It is discovered that those who are unable to properly handle milk in other forms can digest and assimilate dry milk without any trouble, accompanied by a marked gain in weight.

During the period from 1915 to 1919 I was medical inspector of the children in the public schools of Floyd County, Georgia. I made examinations of 20,000 school children. My conclusions were that malnutrition was playing havoc with many of the children. Just how to overcome it was another question. Practically all of those showing marked evidences of malnutrition had been given little or no milk at home and not any at school.

\*Read before the Medical Association of Georgia, May 13, 1925.



To provide fresh milk at school was a difficult matter, because there were no convenient means of keeping it fresh and safe. In November, 1924, I addressed one of the local parent-teacher associations in my city and urged that some plan be devised to test out the value of a half pint of milk a day to each child in the first four grades of the school, in addition to at least a half pint taken at home. The suggestion was carried out and resulted in a most encouraging report from the teachers. The suggestion has been followed by other neighboring schools with like good results. The difficulty in obtaining and keeping fresh milk at some of the schools is the great trouble with this plan.

In *The Nation's Health Magazine* of April are the results of quite an interesting experiment with dry milk as part of the school lunch. The test was made on 116 children of the first four grades of a village school in northern New York State. Each child was carefully examined by the school physician. Many of these children had advanced malnutrition. The children were given dry milk over a period of 24 weeks and the results were observed. Some took dry milk at school and raw milk at home. Others took dry milk entirely. The summary of the test is shown here in its results.

**Group..... Average Individual Gain**  
*On basis of milk consumption during milk feeding period.*

	Prelim- inary Period lbs.	Milk Feeding Period lbs.
Entire group .....	1.07	2.33
Dry milk at school, raw at home .....	1.26	2.32
Dry milk only.....	.42	2.92
Milk at home only.....	1.13	2.19
No milk whatsoever.....	.62	1.09
Under weight and received dry milk .....	.39	2.36
Under weight and received no dry milk.....	.75	1.09

The remarks of the school physician concerning this test were as follows:

"It will be observed that the largest increase in gain is found in the group receiving

dry milk only. The data presented herein shows that measurable benefits can be expected from the use of dry milk as a corrective for malnutrition. The results are not unexpected in view of those which have long been observed from the use of this product in infant feeding. The data merely serves as additional information showing that this form of milk has a nutritive value comparable to natural fluid milk and other milk preparations. Further significance of the results lies in the fact that this form of milk embodies the factors of convenience and bacterial purity to the degree which enhances its adaptability for use where such factors are presented for practical consideration."

One can readily see the advantage of dry milk, which has nothing added to it, for many infants, especially the difficult feeding cases, when he takes into consideration that many such infants have an intolerance for the various sugars and starches found in some mixtures where dry milk is used as one part with the combination of sugars and starches. These ingredients may be added to dry milk if considered necessary in such proportions as needed in each individual case.

My experience with dry milk has been rather extensive, since I have had opportunity of observing a test out in approximately 2,000 infants extending over a period of six years. I looked upon this form of milk at first with considerable doubt, but I determined to give it a fair trial. I first sought to understand dry milk, and then began to try it out on some of my difficult feeding cases. The results were most satisfactory from the beginning. Numerous cases where I have failed to get an undernourished infant to thrive on raw cow's milk, I was able to get at once a satisfactory response in the use of dry milk.

I have had scores of undernourished and vomiting babies referred to me who seemed to have been given a short trial on every known food, and with no improvements. Without exception the happiest results have been obtained in such cases by the use of dry milk. It comes nearer being "fool proof" than any other food I have tried for babies. But it is necessary for the physician to give some special study to this food to get the best results.

A number of reliable firms manufacture dry milk, and I have tried the product of most of them. Personally I have had decidedly the best results from dry milk manufactured by the Dry Milk Co., of New York, known as Dryco. I like the idea of Dryco, because it has nothing in it except the solids of fresh milk. I like the 2 per cent fat content for the difficult feeding cases, also the slightly higher protein. It seems to meet every need of the poorly nourished child. I never use or recommend condensed milk in infant feeding. There is where we usually get our scorbutic and rachitic babies. In my observation very few cases of scurvy or rickets have appeared in infants except those fed over long periods on condensed milk, which is relatively high in cane sugar and very low in fats and protein. Condensed milk often makes fat babies, but usually these babies have a low resistance.

I believe as you do of course that a baby should remain at its mother's breast during the first year of life if all is right with mother and child. Again there are many robust babies who could during the first year be weaned and put directly on raw cow's milk and do well. Yet for the rank and file of early weaning cases, and those belonging to the class of difficult feeding, even beyond the first year, in my opinion there is no better food offered the profession than dry milk. Some of my feeding cases have been about as difficult as it is possible for any physician to treat. These usually reach me with the history that the infant had to be weaned at birth and had been tried on every available kind of milk, but it would vomit everything, cry all the time, and lose constantly in weight. By the time baby reached my office it was a starved, emaciated form. But without exception these babies quit vomiting and began to thrive on dry milk, and in the majority of cases gave no further trouble.

In adjusting any kind of milk modification to such undernourished infants of course it is necessary to begin with a very weak mixture and gradually increase it as the baby is able to take more. Most physicians using the "Dryco Brand" of dry milk, I believe, give in the 24 hours three tablespoonfuls of dry milk to each pound of body weight of the infant. Inasmuch as each tablespoonful has the equivalent of sixteen calories, the above

rule would be giving the infant approximately fifty calories for each pound of body weight, a very good rule. But it seems to me safer and better for baby during the first six months of its life to disregard the theory of calories and feed according to age. Some babies at birth weigh more than other babies four months of age. As a guide in such matters, up to six months of age, I generally adopt the method of giving at each feeding one more level tablespoonful of Dryco than baby is months old, and use from a half to an ounce more water than I use tablespoonfuls of Dryco. I find more cases where the age rule will work during the first six months than the caloric method. After six months I routinely adopt the caloric method of feeding.

Suppose a baby weighs 12 pounds at birth. According to the weight and caloric method it would require 36 tablespoonfuls of Dryco in one day. If we gave it three-fourths full strength, it would require 48 ounces of water, or three pints in one day. When you take into consideration that a new born infant's stomach holds only about one and a half ounces, how are you going to get 48 ounces into its stomach in 24 hours? After following the age method for the first six months it will be very easy to swing to the weight and caloric method. Physicians often fail in getting results with dry milk on this one point.

Before giving any case histories I would like to add that in feeding dry milk to difficult cases one has all to gain and nothing to lose. My experience has led me to believe most firmly that in many cases it suits the infant's requirements better than any other kind of artificial food. Any medical man who condemns the use of dry milk, at least in a selected class of cases, has perhaps not used enough to observe its superior value in such cases. While I find dry milk to be the simplest of all artificial foods for infant feeding, it does require some study to give it satisfactorily in difficult feeding cases.

(Illustrating the use of dry milk where the usual food disagreed.)

June 2	Baby M	Age—3 mos.
(Birth weight, 8 lbs. 12 oz.)		
(Present weight, 8 lbs. 4 oz.)		

Weaned at the end of the first month by the attending physician. Diagnosed by three previous

physicians as pyloric stenosis.

General condition: Poorly nourished.

Stools: Very hard and mixed with undigested milk.

Vomiting: Projectile in character after every feeding.

Appetite: Good.

Sleep: Restless and fussy. Takes only short naps and usually wakes vomiting.

Temperature: 98.8 in rectum.

Chief complaint: Vomiting, fussy and failure to gain.

Previous food: Nursed one month, followed by diluted raw milk; klin, malted and condensed milks.

Treatment:

Dry milk, 1½ tablespoonfuls.

Water, 3 ounces.

Fed 3 ounces every 3 hours at 6, 9, and 12 A.M. and 3, 6 and 9 P.M. and each week a slight increase of dry milk and water were added so that at the end of the first month, July 2nd, weight 9 lbs. 8 oz. Gain 1¼ lbs.

General condition: Improved.

Stools: Two, normal.

Vomiting: Very seldom.

Sleep: Good.

Appetite: Good.

Treatment: Gradual increase in same food.

The vomiting was much diminished from the start, and after one month it practically ceased. There was a steady gain in weight, and on Oct. 2nd, four months later, the baby weighed 17 lbs., a gain of 8 lbs. and 12 oz. In fact, it had over doubled in weight and was in excellent health. I should have told you that the infant cried so much prior to the time I saw it that on the first trip to my office I found it with a strangulated right inguinal hernia. That was promptly relieved under an anesthetic and did not again return.

Sept. 1                      Baby S                      Age—6 mos.

(Birth weight, 7 lbs.)

(Present weight, 5 lbs.)

General condition: Greatly emaciated.

Stools: Frequent, mucous in character.

Vomiting: After each feeding.

Appetite: Only moderate.

Sleep: Short naps day and night.

Temperature: 99 rectal.

Chief complaint: Losing weight, mucous stools and little appetite.

Previous food: Weaned at 2 months by attending physician, was tried on condensed milk, malted, and raw cow's milk.

Treatment: Food prescribed.

Dry milk, 1 level tablespoonful.

Water, 2 ounces.

Because it was necessary to begin this six months' baby, which weighed only 5 lbs., on a very diluted mixture and small quantity, I fed baby every 2 hours during the day for the first month, then went to 2½ hour periods, and finally to every 3 hours, as I feed most of my babies.

Once each week the stools were examined, baby weighed, and food gradually increased in strength and quantity. On Oct. 1st, one month later, weight 7 lbs., gain 2 pounds.

General condition: Greatly improved.

Stools: Two, normal.

Vomiting: None.

Appetite: Excellent.

Sleep: Good.

Treatment: Food unchanged except to gradually increase strength and quantity.

There was a gradual gain in weight from the very beginning due to the use of dry milk, and on Jan. 1st, four months later, baby weighed 14 pounds, a gain of nine pounds.

I could read hundreds of similar case reports with like results following the use of dry milk. But the two reported here are sufficient at this time. The use of dry milk is simple and any intelligent person can very soon learn to use it with best results.

This milk is made fresh at each feeding by adding the proper quantity of water to it. So one is running no risk of spoiled milk from the absence of ice, a very attractive feature for many homes in the summer, especially in the rural communities. The milk may be given with uniformity of strength, while raw milk varies greatly in fat content unless one adopts the skimmed milk and cream percentage method, which is rather difficult for the average home. When changing localities the mother who feeds her infant on dry milk is not confronted with the dangers of changing the baby's milk from different herds, which some experience. Dry milk keeps well. Therefore, the danger of giving contaminated milk is eliminated. I adopt it as a routine to give all babies, breast babies included, orange juice after the fourth month (not after weighing ten pounds, for some weigh that at birth). I give the breast baby and the raw cow's milk baby thus the same protection from scurvy as the dry milk baby. In the entire series of infants fed on dry milk, I have found only two with intolerance to milk protein. I reduced the amount of dry milk so as to reduce the protein intake and substituted one of the sugars to take care of the loss in calories, and had no further trouble. In all of this large series I have followed up at least 75 per cent of them and have found no case of rickets or scurvy. My experience with dry milk resolves itself into these virtues: safety and simplicity of use,



greater digestibility and high nutritive value.

In conclusion I wish to ask that before a medical man condemns dry milk as one of the best possible foods for malnutrition and difficult feeding cases, let him give it the same fair trial that I have given it, and I believe he will be as enthusiastic for it as I am. I will close my remarks with a quotation from Brennemann:

"The advantages of dried milk are so obvious that it has become increasingly popular within the last few years. That dried milk is more easily digested by the baby that does not digest fresh milk satisfactorily, or by any baby, can be doubted or denied only by those whose prejudices have not permitted them to use it. Just as boiled milk is easier to digest than fresh milk, so dried milk is easier to digest than boiled milk, and probably for the same reason."

---

**INTRAVENOUS MERCUROCHROME IN  
TREATMENT OF ACUTE ARTIC-  
ULAR RHEUMATISM  
(Rheumatic Fever)  
J. F. Covington, M.D.  
Moultrie, Ga.**

On November 29, 1924, Erliene Covington (my little daughter), age nine, was attacked by acute tonsillitis and was given the usual late method of treatment for that trouble and got along nicely until December 2, 1924, when she was attacked by acute articular rheumatism (rheumatic fever), at which time she was given Sodii Salicylate Gr. V with Sodi Bicarbonate Gr. V every 3 hours, also Tr. Aconite m 2 every 3 hours. Under which treatment she did not improve.

I will state that all the joints of her extremities were very sore and swollen and her temperature ran about 101 to 103 with considerable discomfort and much pain on mobilization.

On December 4th, I had prepared 10 c.c. of a 1 per cent sol. Mercurochrome 220 soluble and I invited my good friend, Dr. Jim Summerlin, President of the Colquitt County Medical Society, to assist me and we gave her 9 c.c. of this solution into the cephalic vein, losing about one c.c. by her jerking her arm and pulling the needle out and having to

reinsert it we got some of the solution interdurum and caused considerable cellulitis.

In two hours after the injection the child was entirely free of pain and the urine that time showed pink. In six hours she had no swelling at all. She slept at least 50 per cent of the time and rested fine at all times. She did not have the usual nausea and looseness of the bowels, neither did she have the chill that sometimes follows this treatment.

In 24 hours she was sitting up in bed laughing and singing, playing with her baby sister. In 48 hours all temperature had disappeared and she was as well as ever except the weakness that would follow any case of toxemia following tonsillitis. Her pulse during the 48 hours ran around 128 to 135.

I am advancing the theory that the drug does leave the blood by osmosis and incorporates itself in the lymph and tissue fluids, thereby, coming in close contact with the areas of consolidation and the invading organism.

The rule is to give 23 c.c. to the 100-pound body weight; but, I did not do that in this case as the child weighs about 60 pounds. She should have had about 15 c.c. However, the results were all that could have been wished for. The child was up in three days and never complained any more and was soon back in school. She has not had any trouble since, and I do not expect any. I am glad to state that the heart was not affected as is usually the case in rheumatic fever.

Had she not had this treatment at once the heart would have been involved and the fight would have been greater. I will state that we have used this treatment in two other cases of rheumatic fever. You need not be afraid to use it in all cases of rheumatic fever. One case we tried out was of five months' standing. We gave the patient two injections of 23 c.c. mercurochrome two days apart with fine results.

---

**ALL IN FIFTY YEARS**

Generally speaking, a man fifty years of age has slept 6,000 days, worked 6,500 days, walked 800 days, amused himself 4,000 days, eaten 1,500 days and has been sick 500 days. He has eaten 17,000 pounds of bread, 16,000 pounds of meat and 4,600 pounds of vegetables, eggs and fish and drunk in all 7,000 gallons of liquid.

# THE JOURNAL

OF THE  
MEDICAL ASSOCIATION OF GEORGIA  
Devoted to the Welfare of the Medical Profession of Georgia.

---

65 Forrest Ave., Atlanta, Ga.

---

AUGUST, 1925

---

ALLEN H. BUNCE, M. D., Editor

Publication Committee

CHAS. USHER, M. D.

S. J. LEWIS, M. D.

T. C. THOMPSON, M. D.

---

Articles are accepted for publication on condition that they are contributed solely to this Journal.

Manuscripts should be typewritten, double-spaced, and the original (not the carbon copy) submitted. Used manuscript is not returned unless requested.

Communications and items of general interest to the profession are invited from all parts of the State. We especially invite county society secretaries to send us information of happenings in the county that would be of interest to the members throughout the State.

Reprints should be ordered within 30 days after the appearance of an article, since all type will be destroyed at the end of that time.

---

## Editorial Department

### DALLAS WILL ENTERTAIN THE SOUTHERN MEDICAL ASSO- CIATION IN NOVEMBER

A warm invitation is being extended to the doctors of the South to attend the annual meeting this fall, and preparations are being made to entertain between four and five thousand. Already, 1,500 rooms in the best hotels have been set aside for this purpose, and it is estimated that more will be available.

Dallas has all the chief requirements for a successful convention city: ample hotels and auditoriums, easy accessibility, facilities for entertainment and diversion, coupled with whole-hearted hospitality on the part of the citizenship. It is not only a medical center of importance, but a city of interest and opportunity.

#### Easily Accessible

Ten trunk line steam railroads serve Dallas, with 100 passenger trains daily in and out of the \$6,500,000 Union Terminal Station. Two hundred and fifty-eight interurban trains leave the \$1,000,000 electric interurban station daily. Dallas is 16 hours by rail from

Kansas City, 18 hours from St. Louis, 27 hours from Chicago or Cincinnati, and 43 hours to New York.

For those who wish to use the automobile in attending the S. M. A. Convention, Dallas is located on five transcontinental highways, Bankhead, Meridian, King of Trails, Dallas-Canadian-Denver, and the Dixie Overland. These highway organizations assure the tourist of well-kept roads. In Dallas County alone are 1,000 miles of surfaced highways, and a tourist camp and centers of highway information are available also.

#### Clubs, Restaurants, Theatrical Facilities

Dallas has a number of strong clubs, splendidly housed, such as Dallas Athletic Club, University Club, City Club, a number of fine golf clubs, and all the leading national service organizations, such as Rotary, Lions, Kiwanis are represented here—all are most hospitable in the entertainment of visitors.

Restaurants, either connected with hotels or independent, are numerous and of a generally high standard. Some of the highest priced chefs in the nation are here. You can get meals with a Western flavor, Mexican dishes, Chinese dishes or old-fashioned Southern cooking. All the year truck gardens and farms are producing in some parts of Texas, and this, coupled with proximity to packing houses, poultry farms and orchards, tends to keep food prices reasonable.

Dallas has 37 theaters, with a combined seating capacity of 28,000. These include summer and winter stock companies, many good road shows during the season, high-class vaudeville and motion picture houses, and the Little Theater which was twice awarded the Belasco Prize. There are theaters costing as much as \$2,000,000 and seating as many as 3,000 persons.

#### Climatic Conditions

Dallas' climate as a whole is pleasant and invigorating, without severe extremes, and November in Texas as a rule is crisp and clear, ideal for travel and for outdoor sports.

Through the medium of this Journal, in later issues, data on the hospital and clinical facilities of the Convention City will be given, meanwhile, the medical profession of Dallas and of Texas invites you to plan to attend

the Southern Medical Association Convention this fall.

CURTICE ROSSER, M.D.,  
For Publicity Committee.

### COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Dr. J. W. Palmer, Ailey, Ga., Chairman of the Committee on Public Policy and Legislation, decided that a sub-committee was necessary in order to make his committee more efficient. This committee has been selected and consists of the Councillor from each District and two other doctors selected by him from his District. In this way, Dr. Palmer hopes to reach every Legislator and Senator in Georgia and inform them of the bills the Association desires to help defeat or pass.

Besides Dr. Palmer, Drs. B. H. Wagnon, Atlanta; W. E. McCurry, Hartwell; Frank K. Boland, President of the Association, Atlanta, and Allen H. Bunce, Secretary-Treasurer of the Association, compose the Committee on Public Policy and Legislation. Those on the Sub-Committee are: First District: Drs. Chas. Usher, Councillor, Savannah; W. K. Smith, Pembroke, and R. L. Miller, Waynesboro; Second District: Drs. C. K. Sharp, Councillor, Arlington; J. M. Spence, Camilla, and Chas. Watts, Thomasville; Third District: Drs. V. O. Harvard, Councillor, Arabi; E. B. Davis, Byromville, and F. M. Martin, Shellman; Fourth District: Drs. O. W. Roberts, Councillor, Carrollton; A. A. Barge, Newnan, and W. P. Jordan, Columbus; Fifth District: Drs. E. C. Thrash, Councillor, Atlanta; D. Houseworth, Douglasville, and R. T. Camp, Fairburn; Sixth District: Drs. M. M. Head, Councillor, Zebulon; Kenneth Hunt, Griffin, and C. C. Harrold, Macon; Seventh District: Drs. M. M. McCord, Councillor, Rome; John W. Good, Cedartown, and Trammell Starr, Dalton; Eighth District: Drs. Stewart D. Brown, Councillor, Royston; W. I. Hailey, Hartwell, and R. M. Goss, Athens; Ninth District: Drs. C. D. Wheelchel, Councillor, Gainesville; George C. Brooke, Canton, and W. L. Mathews, Winder; Tenth District: Drs. S. J. Lewis, Councillor, Augusta; George A. Traylor, Augusta, and A. W. Davis,

Warrenton; Eleventh District: Drs. A. S. M. Coleman, Councillor, Douglas; H. C. Wheelchel, Douglas, and Frank Bird, Valdosta; Twelfth District: Drs. T. C. Thompson, Councillor, Vidalia, J. Cox Wall, Eastman, and Earl C. Brinson, Wrightsville.

### NEWS ITEMS

Dr. Frank K. Boland, Atlanta, who is President of our Association, was the principal speaker at a meeting of the Public Health Nurses of the First District Graduate Nurses, which was held in Atlanta, July 6, 1925.

The friends of Dr. J. W. Palmer, Ailey, are sympathizing with him on the recent death of his mother and father, Mr. and Mrs. William Palmer, at their home near Vidalia. Mr. Palmer died just 24 hours after the funeral of his wife.

Dr. W. C. Pumpelly, of Macon, has been transferred from the Macon Hospital, where he has been receiving treatment for heart trouble since January, to the Walter Reed Hospital, in Washington, D. C. Dr. Pumpelly has the best wishes of the Association for a speedy recovery.

Dr. Henry G. Mealing, of Augusta, has been given an appointment as Instructor in Medicine in Charge of Clinical Laboratories and also Assistant Physician in the Johns Hopkins Medical School, Baltimore. Drs. Julian Johnson, of Aiken, and Herbert C. Alder, of Decatur, have accepted appointments as Assistant Resident Physicians in the University of Cincinnati. These three doctors are graduates of the University of Georgia Hospital, Augusta, where Dr. Mealing is now Resident Physician and Drs. Johnson and Alder have just completed their internship. These appointments are not only honors to the doctors themselves but also the Medical Department of the University of Georgia for it makes evident that the school is in a position to put its graduates on full time staffs of the big eastern universities.

The friends of Dr. H. O. Byrd, with offices in the Byrd-Ethridge Building, Atlanta, will regret to learn that he was seriously injured Thursday, July 9th, when the sedan in which he was riding was struck and overturned by another automobile. It was thought that Dr. Byrd had sustained a fractured skull and internal injuries. We hope by the time this Journal comes off the press Dr. Byrd will be well on the road to recovery.



In the July issue of the Journal, page 307, is a list of the fourteen visitors who attended our 1925 annual meeting held in Atlanta, May 13th, 14th and 15th. In this list are included Dr. Haus Leonhertsberger, of Vienna, Germany, and Dr. T. Ayers, of Shantung, China. We were very glad, indeed, to have these visitors with us and hope that it will be possible for them to be with us again next year.

Dr. M. P. Agee, of Augusta, and Secretary-Treasurer of the Richmond County Medical Society, recently sent us in a check for \$75.00 covering 1925 State dues for fifteen members. Every one of these fifteen doctors are new members of the Richmond County Society. We welcome these men as new members and congratulate Dr. Agee on his efficiency as Secretary-Treasurer.

Dr. Charles T. Nellans, 65 Forrest Avenue, Atlanta, has assumed his duties as Physician at the Atlanta Federal Prison. Dr. Nellans came into office upon the resignation of Dr. A. F. Quillian, Atlanta.

Drs. Herschel Smith and E. B. Anderson, of Americus, announce that Dr. Henry A. Smith is now associated with them. Dr. Smith was graduated from Mercer in 1918 and Emory University School of Medicine in 1923. He then entered Grady Hospital, Atlanta, where he served on the medical and surgical staff until June of this year. Dr. Smith will have charge of the laboratory and x-ray work for Drs. Smith and Anderson.

Drs. H. Taylor Compton and J. C. O'Neill, Savannah, have been appointed to succeed the late Dr. DeLamar Turner as Richmond County Physician. They will divide the work and salary of the office. Dr. Lawrence Lee, Savannah, was appointed a member of the Richmond County Board of Health to fill the unexpired term of Dr. Turner.

Dr. James L. Campbell, Atlanta, addressed the Americus Rotary Club on the subject of cancer, July 7, 1925, at the invitation of Dr. E. B. Anderson, Chairman of the Program Committee. Dr. Campbell is Chairman of the Cancer Commission of the State Association.

Dr. L. W. Williams, Savannah, spoke before the Savannah Lions Club on the necessity of a municipal hospital for the city of Savannah. A Committee, composed of Drs. Williams, J. R. Graves and J. R. Bean, retiring President of the Club, was appointed to work out the plans and make their report at the next meeting.

Drs. Henry W. Shaw, Augusta, and W. B. DuVall, Atlanta, have been appointed trustees for the alumni fund of the university of Georgia Medical College. This fund is provided by the alumni of the College for the education of doctor's children. Dr. W. H. Goodrich, Augusta, is Dean.

Dr. J. Raymond Graves has resigned as House Physician of the Telfair Hospital, Savannah, to devote more time to his private practice. Dr. E. L. Warren, of the University Hospital, of Augusta, succeeded Dr. Graves.

Dr. Harry Ainsworth, of Thomasville, has been elected Secretary-Treasurer of the Atlantic Coast Line Railroad Surgeon's Association, at the meeting held recently at Wrightsville Beach.

Dr. Robert Burford, son of Dr. and Mrs. R. E. L. Burford, of Brunswick, has returned from Vanderbilt, Nashville, Tennessee, where he was graduated a few days ago, receiving his M.D. degree.

Dr. Thos. H. Hancock, Atlanta, President, presided over the meeting of the Surgeons and Physicians of the Central of Georgia Railway in Georgia, Tennessee and Alabama, which was held in Macon, July 22nd. Dr. Craig Barrow, of Savannah, is Chief Surgeon and was among the Delegates present.

Alto Sanitarium now has on hand \$500,000 appropriated for the building of a new anti-tuberculosis sanitarium. Two hundred and fifty thousand dollars of this amount was recently put to the credit of the Sanitarium from funds collected from the state tax on cigars and cigarettes.

Dr. Newdigate M. Owensby, Chief of the Neurological Department, White Unit, Grady Hospital, announces that the Hospital is now conducting its Out Patient Clinic in the new Elsas Clinic Building on Fridays at two o'clock instead of Thursday. All white charity patients suffering with Neurological, Psychiatric or Neuro-surgical Diseases should be referred at this hour.

The Southern Pediatric Seminar held its fifth session August 3-15, 1925, at Saluda, North Carolina. Dr. W. A. Mulherin, of Augusta, is Dean of the Seminar. Georgia doctors giving lectures included Drs. W. A. Mulherin, Augusta; W. L. Funkhouser, Atlanta, and A. J. Waring, Savannah.

Dr. Chas. Usher, Chief of the Staff, presided and Dr. A. A. Morrison acted as Secretary, at the meeting of the Savannah Hospital, held at the hospital July 9th. It was recommended that Dr. H. H. McGee, Jr., be added to the Staff. Twenty members were present.

In giving a talk before the Rotary Club, Dr. Charles C. Harrold, of Macon, stressed the fact that Griffin is large enough for a full time health officer. He stated that Griffin was no longer a small town, that it had a population of 15,000 people and that it was rapidly growing.

Every Mason in Brunswick contributed voluntarily to the fund for the Masonic tuberculosis hospital at Alto. The Masons of Georgia are raising funds to build a hospital at Alto costing \$85,000, which will be open to the Masons of the state.

The Griffin Hospital, Griffin, now spick and span. Inside and out have new coats of paint and paved walks have been laid at the entrance of the building and in the rear. It is one of the few hospitals in Georgia large enough to graduate nurses.

Dr. G. T. Bernard, Augusta, read an instructive paper on "Radium in the Treatment of Cancer", before the regular monthly meeting of the Richmond County Medical Society. Dr. E. A. Wilcox led the discussion, followed by Drs. John Sherman, A. A. Davidson, Edgar Pund, Hugh N. Page and A. C. Wade. The Society is holding its meetings out in the open so that the members will not suffer from the heat.

Parke, Davis & Company, Detroit, Michigan, have opened a depot in Atlanta to better serve their clients. The entire second floor of the building located at 95 Luckie Street will be utilized. A complete stock of pharmaceutical and biological products will be carried. Parke, Davis & Company run an ad on the back cover of our Journal.

The DeKalb County Odd Fellows are planning to build a general hospital in DeKalb County. Their idea is to establish a county hospital in DeKalb, build and operate it by the county, on the same principal that Grady is operated in Atlanta; fraternal organizations to assist in establishing the hospital.

The Medical Department of the University of Georgia held its third University Extension Clinic in Arlington, June 10th. Twenty-five physicians from the Tri-County Society (Early, Miller and Calhoun Counties) attended. The purpose of this

Clinic is to bring new ideas and developments in medicine to the doctors without the expense of going away and taking courses. These Clinics have been most enthusiastically received; ten invitations having been received by the College for clinics next year from other counties. Drs. W. A. Mulherin, V. P. Sydenstricker and H. B. Neagle, all of Augusta, have had charge of conducting the Clinic.

The Newnan Hospital, Newnan, Coweta County, is now open to the public.

The Wesley Memorial Clinic has been formally opened to the public. The Clinic is in connection with the Wesley Memorial Hospital at Emory University. It is said to be the only clinic in the South which will give free medical attention to patients from all sections of the South. Dr. R. A. Oppenheimer, Superintendent of the Hospital, is in direct charge of the work.

The Central of Georgia Railway will build a sixty-bed hospital for its employees. The hospital is to be built on a site running from Bull Street back to Barnard and between Forty-seventh and Forty-eighth Streets in Savannah. Dr. Craig Barrow, of Savannah, and Chief Surgeon of the system, will direct its supervision.

The Chattahoochee Valley Medical and Surgical Association held its twenty-fifth annual session at Warm Springs, July 14th and 15th.

The Fellowship of Medicine and Post-Graduate Medical Association, of London, England, will publish the first number of their Journal, which is to be known as the Post-Graduate Medical Journal, the official Organ of the Fellowship of Medicine. Subscription price is six shillings and should be sent to the Manager, 1, Bedford Street, London, W. C. 2.

#### AMERICAN BOARD OF OTOLARYNGOLOGY

An examination was held by the American Board of Otolaryngology on May 26, 1925, at the Medico-Chirurgical Hospital, Philadelphia, with the following result:

Passed .....	137
Failed .....	20
Total Examined .....	157

The next examination will be held at the University of Illinois School of Medicine on October 19, 1925. Applications may be secured from the Secretary, Dr. H. W. Loeb, 1402 South Grand Boulevard, St. Louis, Missouri.

### ABBOTT LABORATORIES

The new plant of the Abbott Laboratories, pictured below, and now nearly ready, will be, when occupied, the finest complete pharmaceutical and research plant in the world. Here the newest synthetic, medicinal chemicals are made in large quantities by improved processes, insuring purity and accuracy. Here also are extracted from the crude drugs the medicinal principles used largely throughout the pharmaceutical industry as well as by the medical profession.



Larger quarters will be provided for the extensive research work now being carried on by a large staff of chemists and new buildings are being provided for the manufacture of the well-known Abbott pharmaceutical specialties.

The administrative office of the Abbott Laboratories, located for many years in Ravenswood, will be moved about October 1st of this year to the new plant. The postoffice address will be Waukegan, Ill., 25 miles north of Chicago on the C. & N. W. R. R. About 24 acres of ground are owned by the Abbott Company to provide for the future expansion of their business.

### JOHN ADDISON FORDYCE

By the

#### United States Public Health Service

The death of Dr. John Addison Fordyce on June 4, 1925, has deprived the medical world of an able teacher and research worker. His continued studies and investigations will go down into the annals of modern medicine as distinct contributions to the science and art of Dermatology and Syphilology.

Dr. Fordyce was born in Guernsey County, Ohio, on February 16, 1858. He studied at Adrian College, the Chicago Medical College, and the University of Berlin, receiving the degree of Doctor of Medicine from the two last named institutions, from the Chicago Medical College in 1881 and from the University of Berlin in 1888. As early as 1891 his Alma Mater, Adrian College, from which he previously received the A.B. and A.M. degrees, conferred upon him, as a recognition of outstanding service and achievement, the honorary degree of Doctor of Philosophy.

In 1896 Dr. Fordyce called attention to a disease affecting the mucous membrane of the lips, and consequently known as the "Fordyce Disease".

This gave impetus to a further study of this cutaneous infection by Dr. Fordyce and others, which led to its definite diagnosis and mode of treatment. He is also known for his research in quantitative studies of syphilis from a clinical and biological point of view, neurosyphilis, spinal fluid examinations, congenital syphilis, the pathology of syphilis, and dermatology.

Dr. John Addison Fordyce will be remembered by many students as a skillful teacher and by the medical profession at large for his research contributions to a more complete knowledge and practice of Dermatology and Syphilology.

### NOTED CHEMISTS WILL GIVE AID TO HOOVER

#### Committee Named to Help Map Program for Benefit of Industry

The appointment of an advisory committee composed of outstanding members of the chemical industry to co-operate with the Department of Commerce has been announced by Secretary Hoover.

The purpose of this committee is to assist the chemical division of the department in mapping out a program of work which will be of the most practical and immediate benefit to the industry.

The membership of the committee, as announced by Secretary Hoover, includes Dr. Leo Bakeland, president, American Chemical Society and inventor of bakelite; Dr. A. S. Burdick, president of the Abbott Laboratories of Chicago, and formerly president of the American Drug Manufacturers' Association; Dr. H. E. Howe, editor of the Journal of Industrial and Engineering Chemistry; Dr. Charles H. Herty, president of the Synthetic Organic Chemical Manufacturers' Association; Henry Howard, chairman of the board of governors of the Manufacturing Chemists' Association; G. Ober, president of G. Ober & Sons, Baltimore, and past president of the National Fertilizer Association; E. G. Trigg, president of John Lucas & Co., Philadelphia, and president of the Agricultural Insecticide and Fungicide Association; A. Cressy Morrison, president of the Acetylene Gas Manufacturers' Association, and S. W. Wilder, secretary of the Manufacturing Chemists' Association.

### WEST VIRGINIA HAS INJUNCTION AND ABATEMENT LAW

Issued by the

#### United States Public Health Service

The West Virginia State Department of Health is making plans for the enforcement of the Injunction and Abatement Law enacted by the State legislature and effective July 15. The law provides for the closing as a nuisance of any place used for purposes of prostitution, assignation, or



lewdness. A suit in equity may be brought by the attorney general of the State or the prosecuting attorney of the county wherein the nuisance exists. Should public officials fail to enforce the law, a private citizen, resident, or taxpayer may bring in the name of the State a suit in equity to close by injunction a house of prostitution, or one used for purposes of assignation, or lewdness. The law permits the abatement of such a nuisance and perpetually enjoining any person from further maintenance thereof.

According to the United States Public Health Service, there are still ten States without legislation for this purpose. Texas has a law without the abatement feature; the New Jersey law was declared unconstitutional in 1919; and the Maryland law became ineffective two years after the World War.

#### UNITED STATES CIVIL SERVICE EXAMINATION

The United States Civil Service Commission announces the following opening competitive examinations:

JUNIOR MEDICAL OFFICER  
ASSISTANT MEDICAL OFFICER  
ASSOCIATE MEDICAL OFFICER  
MEDICAL OFFICER  
SENIOR MEDICAL OFFICER

Applications for the positions listed above will be rated as received until December 30. The examinations are to fill vacancies in various branches of the Government Service.

For positions in the Departmental Service at Washington, D. C., the entrance salaries are: Junior medical officer, \$3,600 a year for associate medical officer, \$2,400 a year; associate medical officer, \$3,000 a year; medical officer, \$3,800 a year; and senior medical officer, \$5,200 a year. Advancement in pay may be made without change in assignment up to \$2,400 a year for junior medical officer, \$3,000 a year for assistant medical officer, \$3,600 a year for associate medical officer, \$5,000 a year for medical officer, and \$6,000 a year for senior medical officer.

For positions in the field services appointments may be made at the salaries stated above or at higher or lower salaries, the entrance salary depending upon the qualifications of the appointee as shown in the examination and the duty to which assigned.

Competitors will not be required to report for examination at any place, but will be rated on their education, training, and experience.

#### PHYSIOTHERAPY AIDE PHYSIOTHERAPY PUPIL AIDE PHYSIOTHERAPY ASSISTANT

Receipt of applications for these positions will close August 29, September 26, October 24, and November 28, 1925. The dates for the assembling of competitors will be stated on the admission cards sent applicants after the close of receipt of applications.

In the Public Health Service the entrance salary for physiotherapy aide is \$1,020 a year, with quarters, subsistence, and laundry; for physiotherapy pupil aide \$720 a year, with quarters, subsistence, and laundry, or \$1,200 a year without allowances. The salary of physiotherapy assistant is \$1,500 a year, without allowances.

In the Veterans' Bureau the entrance salary for physiotherapy aide is \$1,680 a year; for physiotherapy pupil aide, \$1,000 to \$1,400 a year, depending upon the training and experience of the appointee. The com-

pensation of physiotherapy assistant is \$1,320 to \$1,600 a year.

The duties of physiotherapy aides consist of administering physiotherapy in its several branches—massage, electrotherapy, hydrotherapy, mechanotherapy, thermotherapy; active, passive, resistive, and assistive exercises and remedial gymnastics; keeping daily record of the work and progress of each and every patient coming under direction and treatment; and making the required reports of the activities of the reconstructive work in physiotherapy.

The duties of physiotherapy pupil aides are the same as those for physiotherapy aide, except that they are pupils under the supervision and instruction of the chief aide in all the work above mentioned.

The duties of physiotherapy assistants consist of administering to special cases the treatments of physiotherapy, as massage, electrotherapy, hydrotherapy, thermotherapy, mechanotherapy; active, passive, resistive, and assistive exercises and remedial gymnastics; keeping a daily report of the work in progress on each patient under the appointee's direction and treatment; and making the required reports of the activities of the reconstructive work in physiotherapy.

#### OCCUPATIONAL THERAPY AIDE OCCUPATIONAL THERAPY PUPIL AIDE

Applications for occupational therapy aide and occupational therapy pupil aide will be rated as received until August 31, 1925. The examinations are to fill vacancies in the Veterans' Bureau throughout the United States, at entrance salaries of \$1,680 a year for occupational therapy aide and \$1,000 a year for occupational therapy pupil aide. Advancement in pay may be made without change in assignment up to \$2,040 and \$1,460 a year, respectively.

Applicants for these examinations must be qualified in arts and crafts. Experience in academic or commercial subjects will not qualify applicants for these positions.

The duties of occupational therapy aides will consist of giving instructions in the arts and crafts, keeping a daily record of the work and progress of each and every patient coming under direction and instruction, and making the required reports of the activities of the reconstruction work in occupational therapy.

The duties of occupational therapy pupil aides will be, under the supervision and instruction of the chief aide, to apply occupational therapy by means of teaching arts and crafts; to keep a daily record of the work and progress of patients; and to make the necessary reports of the activities of the reconstruction work in occupational therapy.

Competitors will not be required to report for examination at any place, but will be rated on their physical ability, and education, training, and experience.

Full information and application blanks may be obtained from the United States Civil Service Commission, Washington, D. C., or the secretary of the board of U. S. civic-service examiners at the post office or customhouse in any city.

Do you know what business was transacted by your Association at its recent 76th annual meeting? Turn to page 335 and become better acquainted with your Association.

## District and County Societies

The Secretary of each county society shall report to the Journal of the Medical Association of Georgia full minutes of each meeting and forward to it all scientific

papers and discussions which the society shall consider worthy of publication.—Constitution and By-Laws, Chap. VII, Sec. 15.

1. Demmond, E. Carson, Savannah.
2. Wood, A. W., Albany.
3. Greer, Chas. A., Oglethorpe.
4. Blackmar, Francis B., Columbus.
5. Pitts, Jno. B., Atlanta.
6. Hawkins, T. I., Griffin.

7. McCord, M. M., Rome.
8. Carter, D. M., Madison.
9. Bennett, J. C., Jefferson.
10. Lee, F. Lansing, Augusta.
11. Penland, J. E., Waycross.
12. Cheek, O. H., Dublin.

### HONOR ROLL

The following is a list of 100 per cent counties for 1925. The date on which each became a 100 per cent society appears after the name of the society, together with the name of the Secretary:

1. Randolph County, Dr. G. Y. Moore, Cuthbert, December 9, 1924.
2. Dougherty County, Dr. J. A. Redfearn, Albany, December 10, 1924.
3. Pike County, Dr. M. M. Head, Zebulon, December 12, 1924.
4. Hart County, Dr. W. E. McCurry, Hartwell, January 3, 1925.
5. Warren County, Dr. A. W. Davis, Warrenton, January 14, 1925.
6. Monroe County, Dr. W. J. Smith, Juliette, January 14, 1925.
7. Lamar County, Dr. John M. Anderson, Barnesville, March 6, 1925.
8. Upson County, Dr. B. C. Adams, Thomaston, March 30, 1925.
9. Emanuel County, Dr. S. S. Youmans, Oak Park, May 5, 1925.
10. Stephens County, Dr. C. L. Ayers, Toccoa, May 11, 1925.
11. Turner County, Dr. J. H. Baxter, Ashburn, May 12, 1925.
12. Evans County, Dr. D. S. Clanton, Hagan, May 14, 1925.

### THIRD DISTRICT MEDICAL ASSOCIATION

One hundred doctors attended the meeting of the Third District Medical Society, which was held June 17, 1925. Turner County was host to the visiting physicians, who gathered at Ashburn at 2 o'clock in the afternoon and were taken over to the Crystal Lake Club House, where the meeting was held.

The invocation was given by the Rev. J. W. R. Jenkins and the address of welcome by Dr. G. C. McKenzie, with response by Dr.

E. B. Davis, President. The scientific program included:

"Angina Peetoris," Dr. J. H. Baxter, Ashburn.

Discussion—Drs. J. T. Stukes, Americus, and F. M. Mullino, Montezuma.

"Blackwater Fever and Treatment," Dr. W. A. Miller, Arabi.

Discussion—Drs. Steve P. Kenyon, Dawson, and G. Y. Moore, Cuthbert.

"The Acute Abdomen," Dr. T. J. McArthur, Cordele.

Discussion—Drs. J. M. Kenyon, Richland, and H. A. Mobley, Vienna.

"Intussusception," Dr. A. R. Rozar, Macon.

Discussion—Drs. John T. Moore, Sycamore, and V. O. Harvard, Arabi.

"Observations on the Gallbladder," Frank K. Boland, President, Medical Association of Georgia, Atlanta.

Discussion—Drs. B. T. Wise, Plains, and R. M. Ware, Fitzgerald.

Dr. V. O. Harvard, Arabi, Counsellor, then gave his report. The minutes were read by Dr. Chas. A. Greer, Oglethorpe, Secretary-Treasurer. This was followed by a barbecue dinner with Dr. W. L. Story, Ashburn, acting as host.

Drs. W. L. Story, Ashburn; F. W. Rogers, Ashburn, and H. M. Belflower, Sycamore, were on the Arrangement Committee.

### FOURTH DISTRICT MEDICAL SOCIETY

At 10 o'clock on the morning of June 18th the semi-annual meeting of the Fourth District Medical Society was held at the Public Library in Columbus. Dr. Mercer Blanchard, of Columbus, President, called the meeting to order. The invocation was given by Dr. John A. Davison, Columbus; address of welcome by Mayor J. Homer Dimon, Columbus; response by Dr. Hugh McCulloh, West Point. The following papers were read at the morning session:

"Electro-Coagulation in Malignant Conditions," Dr. Enoch Calloway, LaGrange.

Discussed by Dr. W. L. Cooke, Columbus.

"Toxemias of Pregnancy," Dr. L. G. Parham, Chipley.

Discussed by Drs. J. C. Wooldridge, Columbus, and J. H. Pennington, Columbus.

At noon the doctors went to Fort Benning for luncheon and inspection of the new post hospital and other points of interest at the Fort as the guests of the Medical Officers of Fort Benning.

The following papers were read at the afternoon session:

"Granulated Lids," Dr. C. B. Carter, Columbus.

Discussed by Dr. W. H. Hadaway, LaGrange.

"Notes on Treatment of Malarial Fever," Major A. T. Cooper, M.C., U. S. A.

Discussed by Dr. J. A. Thrash, Columbus.

"Hints for the Industrial Surgeons," Dr. A. N. Dykes, Columbus.

Discussed by Drs. Enoch Calloway, LaGrange, and C. C. Williams, West Point.

The election of officers resulted with Dr. Hugh McCulloh, West Point, being elected President; Dr. C. A. P. Ebberts, Grantville, Vice-President, and Dr. C. O. Williams, West Point, Secretary.

Carrollton was selected as the next meeting place in September. Drs. E. C. Thrash, W. A. Selman and B. H. Wagnon, from Atlanta, were among the visitors.

The visitors are indebted to the Entertainment Committee, composed of Drs. J. A. Thrash, Mercer Blanchard, C. A. Peacock and O. C. Brannon, all of Columbus, and members of the Muscogee County Medical Society, for such a delightful day.

Dr. Francis B. Blackmar, 1924-1925 Secretary of the District Society, who was in Europe during the meeting, was missed by all present. Dr. W. P. Jordan, Columbus, President of the Muscogee Society, acted as Secretary during Mr. Blackmar's absence.

#### **SIXTH DISTRICT MEDICAL SOCIETY**

The Sixth District Medical Society held its semi-annual meeting at the Foy Hotel, Indian Springs, June 24, 1925. The meeting was called to order at 10:30 a. m. The minutes of the last meeting were read by the Sec-

retary-Treasurer, Dr. T. I. Hawkins, Griffin. The following papers were then taken in their order:

"Case Reports," Dr. W. A. Newman, Macon.

"Report of Extraperitoneal Transplantation of Both Ureters Into Rectum," Dr. C. C. Harrold, Macon.

"Pulmonary Blastomycosis," Dr. D. L. Head, Zebulon.

"The Midwife Problem," Dr. O. R. Thompson, Macon.

"Toxin-Antitoxin," Dr. C. S. Ridley, Macon.

"The Differential Diagnosis of Smallpox," Dr. John M. Sigman, Macon.

"An Unusual Abdominal Condition in a Child," Dr. O. H. Weaver, Macon.

"Our Counsellor," Dr. M. M. Head, Zebulon, Counsellor of the Sixth District.

Immediately following the program dinner was served at the Hotel Foy. The Ladies Auxiliary of the Sixth District joined the doctors after the completion of their program. Dr. E. R. Anthony, Sr., Griffin, was the main speaker after dinner. His subject, "The Grievances of the Doctor," was full of fun and thoroughly enjoyed by all.

#### **TWELFTH DISTRICT MEDICAL SOCIETY**

The following is the program of the meeting of the Twelfth District Medical Society held in Dublin, Wednesday, July 1, 1925:

Invocation, C. D. Graves, D.D.

Address of Welcome on behalf of Laurens County, Judge J. S. Adams.

Address of Welcome on behalf of Laurens County Medical Society, Dr. R. J. Chappell, Dudley.

Response to Address of Welcome, Dr. J. Cox Wall, Eastman.

"Treatment of Goiter," Dr. T. C. Thompson, Vidalia.

"Subphrenic Abscess," Dr. J. W. Edmondson, Dublin.

"The Commonest Cause of Serious Persistent Indigestion," Dr. Frank K. Boland, Atlanta, President of the Medical Association of Georgia.

"Eelampsia," Dr. R. S. Benson, Alamo.

"Pathology and Therapy of the Tonsil," Dr. C. A. Hodges, Dublin.



"Magnesium Sulphate," Dr. J. W. Palmer, Ailey.

The following are the officers of the Twelfth District Medical Society:

President, Dr. W. A. Rivers, Glenwood.

Vice-President, Dr. T. E. Blackburn, Swainsboro.

Second Vice-President, Dr. T. C. Thompson, Vidalia.

Secretary-Treasurer, Dr. O. H. Cheek, Dublin.

### **ELEVENTH DISTRICT MEDICAL ASSOCIATION**

The doctors of the Eleventh District Medical Association met in Brunswick, Saturday, July 11th. Dr. W. C. Hafford, Waycross, President of the Association, presided over the meeting. Dr. J. E. Penland, Waycross, filled his office as Secretary. The Invocation was given by Rev. T. W. Simpson, Brunswick. Dr. J. W. Simmons, Brunswick, gave the Address of Welcome, and Dr. W. C. Hafford, Waycross, responded. The scientific program consisted of the following papers:

"Regional Anesthesia, with Case Reports," Dr. J. A. Dunwoody, Brunswick.

"Pneumonia," Dr. A. Flemming, Folkston.

"Diagnosis and Treatment of Ureteral Stricture in the Female," Dr. J. N. Barker, Montgomery, Ala.

"X-Ray Therapy," Dr. W. J. Buek, Jacksonville, Fla.

"Myocardiac Insufficiency," Dr. E. C. Thrash, Atlanta.

"The Diathemic Treatment," Dr. J. A. Thomas, Valdosta.

"The Much Abused Chronic Dyspepsia," Dr. C. W. Roberts, Atlanta.

"Review of Branham's Syndrome," by the discoverer, Dr. H. M. Branham, Brunswick.

The guests drove to St. Simon and Long Island, where a banquet was held at the Arnold House on St. Simon.

The next meeting will be held in Douglas, January 2, 1926.

### **BROOKS COUNTY MEDICAL SOCIETY**

On July 8th, we received the 1925 report of Brooks County. The delay was caused by the death of their Secretary, Dr. L. A. Felder, Quitman, about the time it should have been attended to. For the year 1925, Dr. G. D. Dorrough, Quitman, was elected President,

and Dr. J. R. McMichael, Quitman, Secretary-Treasurer. Brooks County Medical Society entertained at a reception at the Quitman Country Club in honor of the members of the Lowndes and Thomas County Societies, August 10th.

The members of the Brooks County Society include, Drs. G. D. Dorrough, L. A. Smith, E. L. Jelks, T. R. Moye, W. Mathews and J. R. McMichael, all of Quitman.

### **BURKE, EMANUEL AND JEFFERSON SOCIETIES**

The members of Burke, Emanuel and Jefferson County Societies met at McKinney's pond, near Midville, for an all-day outing and meeting. During the afternoon the following papers were read and discussed:

"Brief Review of Recent Medical Literature," Dr. Ralston Lattimore, Savannah.

"Cancer," Dr. W. H. Myers, Savannah.

"Case Reports of Burns and Anemias," Dr. John W. Daniel, Savannah.

"Hyperthyroidism," Dr. R. L. Rhodes, Augusta.

"Experience with Local and Block Anesthesia," Dr. C. Thompson, Millen.

"Ear, Eye, Nose and Throat," Dr. T. E. Oertel, Augusta.

"Summer Diarrhoea," Dr. W. A. Mulherin, Augusta.

"Operation on Cervix Uteri," Dr. R. C. Franklin, Swainsboro.

"Infant Feeding," Dr. R. L. Miller, Waynesboro.

Everyone present had a great time and such gatherings as this should be encouraged.

### **COLQUITT COUNTY MEDICAL SOCIETY**

The Colquitt County Medical Society held an interesting meeting at the court house in Moultrie, Wednesday afternoon at 4 o'clock, July 1st.

Dr. J. A. Summerlin, Hartsfield, read a paper on "Infant Feeding," and Dr. C. C. Brannen, Moultrie, read the only other scientific paper of the evening, "Case Report of Influenza Followed by Pneumonia, Malaria and Typhoid Fever." Dr. J. F. Covington, Moultrie, gave a report of the Emory Clinics and Dr. J. A. Summerlin, Hartsfield, reported on the recent State Medical Meeting.

Another meeting was held August 5th. Papers were read by Drs. J. F. Covington, Moultrie, and W. H. Whittendale, Norman Park.

## Medical Progress

With the cooperation of our associates we propose to publish under "Medical Progress" abstracts from current medical literature of general interest to the

profession. Members of the association are invited to contribute to this Department.

Anderson, W. W., Pediatrics  
Ballenger, E. G., Urology  
Bartholomew, R. A., Obstetrics  
Block, E. B., Neurology and Psychiatry  
Clay, Grady E., Ophthalmology  
Dowman, C. E., Neuro-Surgery  
Eguen, M. S., Otolaryngology and Rhinology  
Fitts, Jno. B., Internal Medicine  
Greene, E. H., Surgery

Hodgson, F. G., Orthopedics  
Holmes, Walter R., Gynecology and Female Urology  
Jones, Jack W., Dermatology  
Klugh, Geo. F., Clinical Pathology  
Landham, J. W., X-Ray and Radium  
Pruitt, M. C., Proctology  
Thrash, E. C., Internal Medicine  
Waits, C. E., Surgery

### INTRACRANIAL TUMORS

Charles E. Dowman, M.D.,  
Atlanta, Ga.

(Continued from July issue)

**PATHOLOGY:** According to Ewing the various tumors which may occur within the cranial cavity, grouped according to their general localization, are as follows:

1. Pituitary and Suprasella Tumors.
  - A. Tumors of the Pituitary proper.
    1. Diffuse hyperplasia and adenoma.
    2. Adenocarcinoma.
    3. Atypical carcinoma (sarcoma?).
  - B. Tumors of the Hypophyseal Duct and Its Derivatives.
    1. Simple cyst of Rathke's pouch.
    2. Epidermoid carcinoma.
  - C. Tumors of Pars Intermedia.
    1. Adenoma (rare).
  - D. Tumors of the Posterior Lobe (Pars Nervosa).
    1. Glioma.
    2. Lipoma (rare).
2. Cerebral Tumors.
  1. Angioma.
  2. Carcinoma, metastatic.
  3. Sarcoma.
    - a. Primary (?).
    - b. Secondary.
  4. Endothelioma (meningioma).
  5. Glioma.
  6. Cyst.
    - a. Gliomatous.
    - b. Arachnoid.
    - c. Traumatic.
    - d. Echinococcus.
  7. Papilloma (of choroid plexus).
  8. Syphiloma (gumma).
  9. Tuberculoma.
3. Cerebellar Tumors.

#### A. Intracerebellar tumors.

1. Glioma.
2. Ependymal glioma.
3. Gliomatous cyst.
4. Papilloma.
5. Carcinoma (metastatic).
6. Sarcoma (metastatic).
7. Syphiloma (gumma).
8. Tuberculoma.

#### B. Extracerebellar Tumors.

1. Angioma.
2. Cyst (arachnoid).
3. Cholesteatoma.
4. Endothelioma.
5. Acoustic neurinoma.
6. Papilloma.
4. Pineal Gland Tumors.
  1. Cysts.
  2. Teratoma.
  3. Ependymal Glioma.
5. Pons.
  1. Glioma.
  2. Tuberculoma.

A detailed discussion of the gross and microscopic appearance of these various tumors and cysts will not be attempted. You are referred to the work of Ewing on Neoplastic Diseases for such pathological considerations. According to the recent statistics of Cushing gliomas constitute about forty per cent of all intracranial tumors. In his statistics are included tumors of the pituitary gland. If we exclude such tumors as not being essentially of the brain proper the percentage of gliomas is much higher. It is unfortunate that the most common tumor of the brain is the most unsatisfactory as far as treatment is concerned. It is proper to look upon such tumors as essentially malignant in character; this is on account of their infiltrating character and of their great vascu-

larity—conditions which render it impossible as a rule to remove them. Recently Sachs has advanced some very practical ideas in regard to the operability and prognosis of gliomas. He bases his conclusions on a careful pathological and clinical study of some sixty-five cases. He classes gliomas into three clinical groups, namely, gliomatous cyst, cortical gliomas and subcortical gliomas. Microscopically he has found three prevailing types, namely, those gliomas in which the glial nuclei predominate, those in which the glial fibrillae predominate, and those in which the cells are of different sizes and shapes and in which there are numerous giant cells. He claims that the gliomatous cysts and the cortical gliomas belong to the type in which the glial nuclei predominate. He thinks that these tumors are fairly well circumscribed and are relatively benign; also he finds that many of such gliomas can be successfully removed. These tumors which on microscopic examination show a predominance of glial fibrillae are usually subcortical in location and are markedly infiltrating in character. They are therefore poorly differentiated from the surrounding normal brain tissue, and can not be successfully removed. Some of them, however, are so soft and gelatinous-like in character that the bulk of the tumor can be removed by suction. Such a removal, however, will only be partial, and the remaining tumor cells will continue to proliferate unless perhaps controlled by the use of the roentgen ray. The third type of glioma which on microscopic examination shows the presence of various sized nuclei and the presence of many giant cells is extremely malignant in character and as far as is known does not respond to any treatment whatsoever. These tumors (occurring principally in children) are probably of the same type described by Globus as spongioblastomas. They are practically always subcortical in location and usually occur in the cerebellum. Those gliomata which terminate in cystic formation and which according to Sachs' observations are composed of tissue in which the glial nuclei predominate are probably of rather low vitality as otherwise they would not undergo a cystic degeneration. At times this cystic degeneration will go on to an almost complete

disappearance of the tumor cells. The contents of these gliomatous cysts is a yellow fluid which after removal coagulates on cooling. These cysts can not infrequently be successfully treated by treating the lining with some hardening and fixing fluid such as Zenker's Solution. At the present time Bailey of Boston is engaged in the microscopic study of some four hundred gliomas which have occurred in Cushing's Clinic. By using special stains, particularly that devised by the Spanish anatomist, del Rio-Hortega, Bailey has been able to distinguish four distinct types of glioma. It is possible that by a study of the clinical course of the patients falling into these four groups, he will be able to determine the best method of handling each of the four varieties of glioma.

The intracranial tumor which offers the best chance for cure by means of radical removal is the so-called endothelioma. On account of the fact that these tumors always originate from the meninges, Cushing prefers to designate these tumors as meningiomas. These tumors are of variable histological appearance, the picture ranging all the way from very cellular, apparently rapidly growing sarcoma-like neoplasms to fibrous-like tumors composed of endothelial cells arranged in whorl-like collections. These latter are termed psammomas. With the exception of a small percentage of rapidly growing endotheliomas, the majority of such tumors are of a relatively benign character. They are encapsulated and are of slow growth. They do not infiltrate the brain tissue as do the gliomas, but push and distort the surrounding brain. On account of the slow growth of tumors of this nature the brain accommodates itself, as it were, to the intruder. This accounts for the fact that endotheliomas often attain considerable size before giving rise to symptoms. As has already been mentioned, when these neoplasms arise from the dura mater the overlying skull through irritation may become greatly thickened. Such bony enlargements may become manifest in the external contour of the skull, and thereby lead to the condition being falsely diagnosed as osteoma. Such an osseous thickening should always suggest the probability of an underlying dural endothelioma, even in the absence



of cerebral symptoms. When an endothelioma is enucleated it is necessary to remove also that portion of the meninges to which the tumor is attached, as otherwise a recurrence may take place.

The tumors which originate from the acoustic nerve are essentially benign. They are located in the cerebello-pontile angle. They are encapsulated and are slowly growing. The symptoms which are caused by these tumors are primarily those of acoustic nerve involvement and secondarily, through pressure on neighboring structures, of cerebellar involvement. In effecting their removal it is necessary to do an intracapsular enucleation. This is necessary because of the attachment of the capsule to the neighboring branches of the circle of Willis. By treating the capsule with a fixing solution very excellent results can be obtained. These tumors arise from the endoneurium which is peculiar to the acoustic nerve. The microscopic appearance, therefore, is a distinctive one. The growth is composed of two main types of tissue, namely, a dense fibrous tissue and a loose areolar tissue possessing some of the architectural characteristics of glioma. The tumors are therefore not endotheliomas. Endotheliomas, however, may occur in the cerebello-pontile angle and give rise to an identical symptomatology.

I will not comment further on the pathology of brain tumors, although there are tumors which are much rarer than gliomas, endotheliomas and acoustic neuronomas which present many interesting pathological features. Adenomas of the choroid plexus, for example, are of particular interest. They are papillomatous in their appearance and constitute about 1.5 per cent of all brain tumors. They may plug the Foramina of Munro and give rise to marked internal hydrocephalus. When small, in spite of the difficulty of approach, their removal from this site is possible. Foster Kennedy reports a case of this nature in which the tumor was removed by Horsley many years ago.

**SYMPTOMS AND DIAGNOSIS:** The presence of chronic increase of intracranial pressure should always cause one to suspect an intracranial tumor. As a matter of fact, intracranial tumor is of such a relatively fre-

quent occurrence as to justify one in considering all cases with the symptoms of increased intracranial pressure as suspected tumor unless some other cause can be definitely proven. Although cardio-renal disease, severe anemias, and at times lead poisoning may give rise to such symptoms, these conditions can usually be easily recognized.

The three classical symptoms of increased intracranial pressure are headaches, vomiting, and papilledema (choked discs). To these may be added progressive mental dullness, generalized epileptiform convulsions, attacks of vertigo, and diplopia.

**HEADACHE:** This is the most constant symptom of intracranial tumor, and occurs sooner or later in practically every case. The pain is usually of a constant dull character with periods when it may be of agonizing intensity. The slightest excitement or exertion is liable to intensify the headaches. The pain may be general, or localized. It was once thought that when localized the pain would be in or near that part of the head where the tumor was located; a localized pain, therefore, was considered of great diagnostic value. As a matter of fact it is only of relatively infrequent occurrence for a tumor of the brain to give rise to pain localized in the area involved. For example, the headache in cerebellar tumors is not infrequently confined to the frontal region. It is quite true that certain locations may be suspected when the headache is confined to certain regions. For example, the characteristic headache of pituitary tumor is bitemporal in location. Occasionally a case may be encountered in which the headache is always localized in one particular area, which area is exquisitely tender on palpation and percussion. Under such circumstances there may be a tumor in this region which is very near to or on the surface of the brain, thus causing direct pressure on the overlying dura. Unfortunately such a condition is encountered only occasionally. The headaches of intracranial pressure are probably due to the stretching of the dura. It has been proven that although the dura is insensitive to ordinary touch and incisions, it is acutely sensitive to traction.

(To be continued)

## COMMUNICATIONS

Atlanta, Ga., July 11, 1925.

To the Editor:

A few years ago I operated upon a patient and had considerable trouble in collecting my bill; in fact, it required about two years to collect the full amount, which was paid in dribbles. A few weeks ago I operated upon his daughter and the first of the month sent him a rather moderate bill. Ten days later I received a letter from him enclosing check for one-third the amount of the bill and two notes for the balance. He also wrote:

"I was most agreeably surprised to receive your very moderate bill and think you must have shown me unusual consideration. Possibly you were actuated by the same reason as the preacher of whom I heard some time ago. This sky pilot had been filling the pulpit for twenty years in a very poor country community. During all this time he had been receiving the munificent salary of \$25.00 per month, on which he had lived and raised a large family. One day he was called before the board of deacons and informed that in consideration of his long and faithful services they had voted to raise his salary to \$30.00 per month. He declined to accept the raise, stating that he had had so much trouble in collecting \$25.00 each month he'd be damned if he would allow them to impose this additional burden on him."

FRANK K. BOLAND.

June 27, 1925.

Dear Doctor Bunee:

I have just returned from my trip to Florida and as you were so courteous and helpful to me I thought possibly you would like to hear how that far-famed State impressed me.

Mrs. — and I motored down to Tampa for the State Board. We went and came very leisurely, stopping to talk to someone in every town we passed through. Every one was most friendly. We only found one man who had been born and raised in Florida and he said that he was there because he couldn't get away. That was in Floral City and it was a poverty stricken looking place, too.

At about ten and twenty-mile intervals along the road were filling stations run by Northern people. Most of them had only

those filling stations and a very small supply of canned goods to sell, no garden, no chickens, no truck patch, no visible means of livelihood except the filling station. I was reminded of the old joke about the Floridians skinning the alligators in summer and the tourists in winter.

Further down in the State the real estate boom became evident. Tampa was full of real estate agents, and offices, and business was good for this time of year, so they said.

We found the expenses in Tampa comparing very favorably with those in Macon. Florida is a wonderful place for a young man, for a man without a family, or for a man who has money. It is also a wonderful place for the laboring class, for they can always get work, and get paid first-class wages for their work.

There is also plenty of room for every one who wants to go there. All the available land is by no means taken up, or even cleared up.

I was keenly disappointed in the few truck farms I saw. It seemed to me that most people had gone to Florida to try to get rich without work. For several reasons I do not now think that I should like to move to Florida.

How about the State Board? Dr. Rowlett stated that 400 M. D.'s had made application to stand the State Board, only 257 took the board though, and it will be August before we know who passed and who failed.

There were some very distinguished men among the applicants, there were also 40 Emory graduates and 100 doctors who took the board last December.

The examination was very hard, a number of the questions were misspelled, several of the papers had no names on them, and the Chemistry threw even the recent Emory graduates into a frenzy. It was not medical Chemistry at all. I started to send you the questions to look over, but thought perhaps some of the Atlanta boys had shown you theirs. A number of the Florida doctors are beginning to resent so many outsiders rushing in, and one can hardly blame them.

But unless a man has the money to establish a well equipped hospital I think practicing medicine in Florida will be hard skidding.

I had rather stay in Georgia and hope to have the luck to step into a good practice which some doctor is going to leave following the Will o' the Wisp to Florida, and if you hear of such a place, let me know about it. Again many thanks for your many kindnesses and with best personal good wishes, I am,

Fraternally yours,

—M.D.

### MARRIAGES

The marriage of Dr. Harold I. Reynolds, of Athens, to Miss Mary Elizabeth Sims was of interest to the doctors throughout Georgia. The marriage took place at the home of Dr. Reynolds' parents, Dr. and Mrs. W. H. Reynolds, in Lexington, Ga.

Mrs. Sims is the daughter of the late Mr. and Mrs. S. R. Sims, of Americus. She is a graduate of the State Normal and University of Georgia.

Dr. Reynolds was graduated from the University of Georgia and Johns Hopkins. He is a member of the A. T. O. fraternity, a physician to the University, and is President of the Clarke County Medical Society. Dr. Reynolds is prominent in both professional and social life in Athens.

### OBITUARY

Dr. DeLamar Turner died at his home in Savannah, June 23, 1925, at the age of forty-seven. He was born in Sparta in 1877 and took up the study of medicine, giving up a railroad position, in 1908. He received his M.D. degree in 1912 from the University of Georgia, Augusta. Up until 1916 Dr. Turner practiced medicine in Blythe and Milledgeville, when he removed to Savannah. He was a veteran of two wars, having served in the Spanish-American War and the World War as Major.

At the time of his death, Dr. Turner was Health Officer of Chatham County. Several months ago the County Commissioners granted him a leave of absence in which to restore his health. Dr. Turner was a member of the Chatham County Medical Society and the Alpha Kappa Kappa medical fraternity. In 1916 he served the Baldwin County Medical Society as President. He is survived by his

widow and two daughters, Mrs. F. Basil Abrams and Miss Sarah Turner, of Savannah; one son, DeLamar Turner, Jr.

Dr. Olynthas W. Turner died at his home in Helena, Tuesday, June 16, 1925, following an illness of only a few weeks. Dr. Turner was born July 15, 1843, at Lumpkin. He came to Telfair County in 1891, where he resided until death came.

He was a graduate of the Atlanta Medical College in the class of 1886. He served as a loyal soldier during the Civil War and was an honorary member of the Telfair County Medical Society. His friends were numbered by his acquaintances, and his deeds of kindness rendered while carrying on his profession shall live on. C. J. M.

Dr. William T. Gautier was fatally injured in an automobile accident in Los Angeles, Cal., June 18, 1925.

Dr. Gautier was formerly of Columbus, having moved away eight years ago. During these eight years Dr. Gautier has kept up his membership in the Muscogee County Medical Society. He gave up his practice several years ago on account of declining health. His body was brought to Columbus for burial. Dr. Gautier is survived by three daughters, Miss Eugenia Gautier and Mrs. Clifton L. Johnson, of Los Angeles, and Mrs. William Griswold, of Hannibal, Mo.; and a son, William Gautier, of Texas.

### ANURIA RELIEVED BY URETERAL CATHETERIZATION IN A CASE OF RENAL HYPOPLASIA

Julia C. Strawn, Howard Chislett and Daniel N. Eisendrath, Chicago (Journal A. M. A., May 2, 1925), relate the case of a patient who had a right kidney which failed to develop; it was in a condition of hypoplasia. Following exposure to cold, by falling into the water and lying on the sand until his clothes were dry, there was an acute congestion of the left kidney, followed by colicky pains—a not infrequent accompaniment of such acute congestion. The burden of urinary excretion was thrown on the right (embryonic) kidney, which was unable to carry the burden, with the resultant almost complete anuria and symptoms of renal insufficiency. Ureteral catheterization gave relief.



# Proceedings of The Seventy-Sixth Annual Meeting of Medical Association of Georgia

## Atlanta, May 13, 14 and 15, 1925

### FIRST GENERAL MEETING

Wednesday, May 13

The Association was called to order at the Atlanta-Biltmore at 10:15 A. M., by the President, Dr. J. O. Elrod, Forsyth.

The President invited all the Ex-Presidents in the audience to come to the platform.

Dr. J. W. Daniel, Dr. E. C. Davis, Dr. J. G. Dean and Dr. J. W. Palmer responded.

Invocation, Rabbi David Marx, Atlanta.

Source of light and all life, Thou who art the Father of all men, who in Thy wisdom and in Thy kindness and love dost not prohibit anyone to approach Thee and call upon Thee by the name of Father, we assemble for serious work, to bind up the wounds, to heal the sick, to cause those who are disabled to walk, knowing that without Thy help human help is faulty. We approach unto Thee in a spirit of reverence and ask that Thy blessing rest upon this gathering. Thou who art the great Healer of the wounds of life, we, Thy disciples, in an effort to co-operate with Thee in the healing of mankind, ask that Thou grant unto us the wisdom and the understanding so that as co-laborers with Thee we may cause to return unto health and happiness those who come to us asking that we be of service unto them. Without Thee do they that build on sand labor in vain. So, too, without Thy kindness and Thy assistance human efforts are largely nugatory. So we ask of Thee that Thou strengthen us in character as well as in ability, so that through the observance and the instruction in moral law we may also serve in the advancement of a knowledge that is true of the laws that are physical. In reverence do we ask it of Thee that Thou send a large portion of Thy grace unto us and unto humanity, that Thy name may be praised through our efforts. Amen.

Address of Welcome, Dr. Theodore Toepel, President of the Fulton County Medical Society:

Members of the Medical Association of Georgia:

In the gathering of this distinguished body, meeting in Atlanta today, the Fulton County Medical Society is honored in being your host and, as its spokesman on this occasion, let me extend to each and all of you a most hearty welcome. May your sojourn in our city as our guests be one of profit and pleasure to you, remembered by all of you as "the meeting in Atlanta," the best session of its kind you have ever attended.

The Fulton County Medical Society can look back upon some very interesting history. The first society in Atlanta of which we have any knowledge and, unquestionably, the first that ever existed here, was founded in 1855 through the earnest efforts of Dr. John G. Westmoreland, coincidentally with, or about the same time, that teaching in the Atlanta Medical College was inaugurated. It was known as the "Brotherhood of Physicians," which name was changed to the "Atlanta Medical Society" in 1857. Judging from the available list of doctors practicing at that time the society had about twenty-five members.

Many of you will remember the memorial stormy night session at Marist Hall in April, 1905, with Dr. W. P. Nicholson, Sr., in the chair, when a majority voted that county societies supplant local societies as component parts of the State Medical Association, after a system proposed by the American Medical Association.

At that time the Fulton County Medical Society began with a nucleus of those members already on the Society's roll of 143. Today it gives me a special pleasure to welcome you, supported by a membership of 392 members, and a home of our own in which a library of 900 volumes is housed, which is being extensively used by the members and medical students. I extend to every one of you a most cordial invitation to visit our home at this time or any other time you are in Atlanta. There you will find a quiet place to rest and read. You will find posted a bulletin, giving you daily the important medical clinics and operations in all the hospitals in the city.

It is not possible at this time to mention all the men who in the early history of Atlanta medicine stood out prominently in medical and literary achievements and whose fame traveled far beyond the boundary line of Georgia; but special mention should be made at this time of Dr. J. G. Westmoreland, who did so much to organize the Atlanta Medical College, and who was its first dean; Dr. W. F. Westmoreland, who as surgeon had gained national recognition; Dr. Alexander Means, who possessed a world-wide reputation as scholar and scientist; Dr. H. V. M. Miller, whose oratory had given him the name of the "Demosthenes of the Mountains." He was also an able physician and surgeon. Of the

latter period such men as A. W. Calhoun, J. S. Todd, W. S. Elkin and many others stand out prominently as leaders of progressive medicine.

With a foundation laid by such eminent men it is not surprising that Atlanta today ranks pre-eminently as the best known medical center between Baltimore and New Orleans.

The medical department of Emory University, whose teachers are endowed with the best fundamental knowledge of the medical sciences, is the culmination of the dream of the early pioneers of local and Southern medicine. It is an institution of which every member feels justly proud.

The Graduate School of Medicine and Surgery, the latest addition to medical institutions of learning in Atlanta, will be a factor in furnishing a place to the practicing physician in which he may brush up, and acquire the latest methods of diagnosing and treating medical and surgical cases. Its staff is composed of earnest, painstaking and scientifically trained men, and the facilities are unsurpassed in this section of the country.

Splendid and adequate hospital facilities are available in and near Atlanta; some of the hospitals are among the most modern institutions of their kind in the United States. As hospital facilities are closely connected today with progressive medicine, it may not be amiss to call your attention to the number of available hospital beds in our city. There is a total of 1,650 which are distributed as follows: Private institutions, 260 beds; municipal, 580 beds; public, where there is a staff and any member of the Fulton County Medical Society may take and treat his patients, 730 beds; and two hospitals for colored patients, 80 beds.

Although our program is a heavy one, some of you may find time to visit one or more of our eighteen hospitals.

Again, in behalf of the Fulton County Medical Society, I welcome you most heartily.

Response to Address of Welcome, Dr. W. R. Dancy, Savannah.

Mr. President, Members of the Medical Association of Georgia, and Guests:

We have just received from the medical profession of Fulton County, through the President of their Society, a most cordial welcome to everything within their possession, everything within their power to give. More fitting and sincere words extending the wonderful hospitality of this city could not have been uttered, and no more representative and beloved member of the profession could have

been selected than he who has so nobly spoken.

In reply to this address of welcome it gives me profound pleasure, as the representative of the profession of the State at large, to say to our confreres of the Fulton County Medical Society that we accept with grateful hearts the many invitations extended and the wonderful hospitality offered. The evidence of your cordiality and friendship is to be found everywhere. At the same time, I would warn you that this acceptance is made in the same earnest and sincere manner in which it has been extended, which means that each and every one of us fully expects to avail himself of the wonderful opportunities that this visit to your lovely city affords.

We are indeed fortunate to be guests in Atlanta, whose profession has made such remarkable strides in medical progress and which offers to us, for the asking, splendid opportunities at this time for broadening our professional horizon and our medical knowledge. Here we find the unexcelled Steiner Clinic for the study and treatment of cancer. The Emory University Hospital and Medical School. The Scottish Rite Hospital for Crippled Children and many other hospitals and sanitarium, both public and private. We congratulate and commend you, our hosts, for your energy and enterprise in establishing these splendid institutions. In them you are destined to accomplish a great and beneficial work. Such results of labor unselfishly applied will win for you an enviable distinction in the forefront of medical progress. We of the State of Georgia are proud of you. Not only because you are Georgians—native or acquired—but because you represent no distinctive section. You are a cosmopolitan group. You are of the State at large. You hail *not only* from Fulton County, but from the Valley of the Savannah to the Valley of the Chattahoochee; from the red clay hills of Chickamauga and Rabun Gap, to the historic marshes of Glynn, and to the milky way of human kindness, fresh from the bosom of mother ocean, where she soothes the scintillating sands on Tybee's strand in Savannah's clime.

To be a Georgian is great; to be a progressive Georgian is greater. Once a Georgian, always a Georgian, which recalls a very euphonious remark made some years ago by a great Georgian, Judge Robert Falligant of Savannah. Referring to the little crab-like crustaceans called "fiddlers," which inhabit the sandy shores and mud banks of our coast, he said, "I would rather be a fiddler on the mud banks of Georgia than a harpist in the Kingdom of Heaven."



This State is in point of size the largest State east of the Mississippi and south of Mason and Dixon's line. It is in many respects the greatest of our Southern States, and is rapidly maturing many of its latent powers and resources. In some particulars, however, it has in recent years lost prestige but with the general awakening of the present day we hope her loyal citizens will soon place her back in her rightful position. It will require great effort and perseverance. In accomplishing this there is a duty for us, as a profession, to perform, and as the whole is the sum of its elements so does the duty of this Association fall on the shoulders of each of us. To you and to me, to the medical profession of the State of Georgia, is given the task of supplying at least one of its great deficiencies. I refer in solemn terms to the Public Health Service. I tell you, gentlemen, this State stands dishonored and we, the profession of Georgia, discounted in the estimation of our sister States and in the eyes of the National Government. Awaken we must and correct our neglect. Do we not appreciate what is lacking? Are the people of Georgia so mentally deficient that conception of this State's vital needs in health cannot be comprehended? Is the Legislature so worked by politicians that it has not time to contribute to the most essential element in the structure of our Commonwealth? No! I cannot believe it! It would seem to be more a lethargy, an encephalitis lethargica, a sleeping sickness, a condition which demands a radical remedy and a prompt cure, or death will surely be the result.

Do you know that Georgia appropriates only three cents per capita for the State Health Board? The lowest sum of any State in the South! Are you aware that Georgia has not merited the continuation of the Rockefeller fund for the treatment of indigenous diseases? Think what other States have done: South Carolina appropriates twelve cents per capita; North Carolina nineteen cents per capita; Florida twenty-five cents per capita, but Georgia only *three cents* per capita to the Public Health Service.

This Association must, by its efforts, individually and collectively, urge the Legislature to appropriate an additional Ninety Thousand Dollars (\$90,000.00) *now* for Public Health work. If this fails the United States Public Health Service will withdraw its support from the State, which would indeed be a calamity, industrially as well as otherwise. It would then be only a matter of time when our descendants, victims of hookworm, malarial fever, and such affections would be subservient, mentally, physically and financially,

to the great hordes from the West and North who now, at this moment, are overrunning our country and purchasing our lands. The Ellis Health Law and similar laws must have our undivided and compelling support. Georgia's economic welfare and progress are at stake.

While speaking of work which we have for the Legislature of Georgia, I am reminded that this Association must measure up to its responsibility, must use its influence to have the Faker Fad controlled. Quackery and charlatanism, the financial distorters and bleeders of the ignorant, must be suppressed. These practices are planned to commercialize the misfortunes of the sick. Never have they served in pestilence and epidemics. Theirs is an unworthy motive. While we have the power to control legislation they should be suppressed. It is our duty to protect the rights and health of our citizens by eradicating all types of Bolshevism which invade the medical realm.

We cannot hope to attain results desired unless we build, build this noble profession of ours on a foundation that will make its power irresistible. We must find our way into the hearts of our fellowmen by service. We must cause to be built in our several sections hospitals, not rest houses, for the sick, and equip them with all modern facilities for maximum efficiency. Confidence will gain the co-operation of the best citizens. No city in the South exemplifies this plan better than does the Atlanta of today. Just here I pause to say that great credit is due to the intelligence and generosity of the citizens of this splendid city, in co-operating physically and financially, with their physicians to provide the splendid hospitals which we find here for the treatment of their populace.

Lastly, and above all, we cannot attain the goal desired for this, the noblest of our professions in Georgia, if we are not at peace among ourselves. I utter an earnest plea for the suppression of dissension, internal politics, petty jealousies, splitting of fees, unfair rivalry, and unethical procedures. We have accomplishments to be attained on the one hand, and enemies enough to be suppressed on the other, all of which will never be done without our united power, without co-operation for the greater ideals of the profession.

For generations the attainments of Georgia medical men have glorified the pages of her history. This must not go for naught. They must be supplemented by deeds and work of the profession of today. Do you know that the first resection of ribs for gangrenous lung was performed in Georgia in 1821, and that treatment of fracture of the femur by the ex-



tension weight method was first done in Georgia? Both of these by Dr. Milton Anthony. Likewise, the first harelip operation, and the first operation for removal of the parotid(?) gland were performed by Dr. Richard Banks before 1850. The Presidency of the American Medical Association has once been graced by a Georgian, Dr. Henry Fraser Campbell, who was born in Savannah in 1824. For his original work on the secretory system of nerves, in 1853, he was made a member of the Royal Society of Sweden. The extension method of treating fractures by weights and pulleys was practiced and published in 1829 by Dr. W. C. Daniel of Savannah, twenty-one years before the Bueks extension apparatus was introduced in New York. Again Georgia came to the forefront when it was recorded that the first abdominal hysterectomy done in America was performed by Dr. Paul F. Eve, of Augusta, in 1850.

Such a repetition of the great deeds of our silent medical heroes would indeed be incomplete without the mention of our peerless discoverer of anesthesia, Dr. Crawford W. Long, of Athens. He was the first to administer ether anesthesia successfully, and before a great time transpires we shall have the satisfaction of knowing that his great work to humanity will be honored by a fitting monument in the Hall of Fame, at our National Capital, that future generations will know of this great Georgian.

These great men have set the pace and example, and we have confidence that the men of Georgia today will measure up to their great standards.

I have spoken of the friendly spirit in which we have been received. I have impressed the friendly spirit in which we reciprocate. I now throw down the gauntlet and say emphatically, without the slightest element of inconsistency, that there is great rivalry today between the Fulton County Medical Society and the physicians of the rest of the State: between Dr. Toepel and his hosts on the one side and the hosts of the remainder of the State on the other. The competition is indeed keen: the rivalry waxeth warm. You, Sir, are endeavoring to excel all Georgia in the warmth of love and affection with which you have and are extending to us Atlanta's magnificent welcome, and we of the State are endeavoring to outrival your wonderful efforts by splendid and enthusiastic manifestations of our hearty appreciation. Happy, indeed, are we to be with you. (Applause.)

## REPORT OF THE HOUSE OF DELEGATES:

Secretary Bunce reported briefly the action of the House of Delegates at its first meetings. (Cf. published report.)

Upon motion duly seconded and carried the report was adopted as read.

The Secretary then read a congratulatory telegram from Mr. C. P. Loranz, Secretary of the Southern Medical Association.

The President: This completes our preliminary exercises, gentlemen, and we will now proceed with the first paper on our program: SCIENTIFIC PROGRAM:

1. Dr. Henry R. Slaek, LaGrange, read a paper on "Myxedema," which was discussed by Dr. Arch Elkin, Atlanta, and in closing by the essayist.

2. Dr. J. D. Gray, Augusta, read a paper entitled "Gastric and Duodenal Ulcer with the Medical Treatment," which was discussed by Drs. George M. Niles, Atlanta; W. R. Daney, Savannah; Hal McC. Davison, Atlanta; L. Holtz, Atlanta; W. E. McCurry, Hartwell; George C. Mizell, Atlanta; T. C. Davison, Atlanta; Willis B. Jones, Atlanta; A. J. Mooney, Statesboro; G. N. Coker, Canton, and in closing by Dr. Gray.

3. Dr. W. H. Lewis, Rome, presented a paper on "Infections of the Biliary Tract Unrelieved by Surgical Intervention," which was discussed by Drs. George M. Niles, Atlanta; W. R. Daney, Savannah; C. W. Roberts, Atlanta; Louis F. Lanier, Rocky Ford; and in closing by Dr. Lewis.

4. Dr. John W. Daniel, Savannah, presented a paper entitled, "Case Reports: Blood Chemistry Findings in Vomiting of Pregnancy; Intestinal Obstruction, etc.," which was discussed by Drs. Hal McC. Davison, Atlanta; W. H. Myers, Savannah; Cleveland Thompson, Millen; and in closing by Dr. Daniel.

5. Dr. L. L. Whiddon, Ocilla, read a paper on "Pellagra and Its Treatment," which was discussed by Drs. J. W. Palmer, Ailey; John M. Poer, West Point; Henry C. Wheelchel, Douglas; Daniel S. Middleton, Rising Fawn; Neal Kitchens, Warm Springs; and in closing by Dr. Whiddon.

6. Dr. H. B. Neagle, Augusta, presented a paper on "Pediatrics and the Public Welfare," which was discussed by Drs. Wm. A. Mulherin, Augusta; Henry C. Wheelchel, Douglas; J. M. Poer, West Point; Theodore Toepel, Atlanta; and in closing by Dr. Neagle.

On motion, the Association adjourned at 2 P. M., to reconvene at 2:30 P. M.

## FIRST DAY—AFTERNOON SESSION

The Association reconvened at 2:40 P. M. and was called to order by Vice-President, Dr. Wm. A. Mulherin, Augusta.

7. Dr. Thomas Bolling Gay, Athens, presented a paper on "The Athens Child Health Demonstration," which was discussed by Drs. H. P. Harrell, Macon; R. L. Miller, Waynesboro; George L. Echols, Milledgeville; Theodore Toepel, Atlanta; J. P. Bowdoin, Atlanta; Henry C. Wheelchel, Douglas; Wm. A. Mulherin, Augusta; and in closing by Dr. Gay.

At this point the President took the Chair.

8. Dr. C. H. Richardson, Jr., Macon, read a paper entitled, "Intraeranian Injuries in the New Born," which was discussed by Drs. Wm. A. Mulherin, Augusta; Allen R. Rozar, Macon; H. P. Harrell, Augusta; M. Hines Roberts, Atlanta; E. N. Gleaton, Savannah; and in closing by Dr. Richardson.

9. Dr. M. Hines Roberts, Atlanta, presented a paper entitled, "Physiological Pigmentation of the New Born," which was discussed by Drs. E. C. Thrash, Atlanta; Wm. A. Mulherin, Augusta; Henry W. Doster, Rocky Ford; and in closing by the essayist.

10. Dr. W. W. Anderson, Atlanta, presented a paper on "Pyuria in Infants and Children," which was discussed by Drs. Wm. A. Mulherin, Augusta; R. L. Miller, Waynesboro; Wm. J. Cranston, Augusta; and in closing by Dr. Anderson.

11. Dr. Joseph Yampolsky and Dr. George F. Klugh, Atlanta, presented a paper on "The Treatment of Syphilis in Children; with Special Demonstration of Intraperitoneal Injections of Neoarsphenamine and Mercurosal," which was discussed by Drs. Wm. L. Funkhouser, Atlanta; Lewis D. Hoppe, Jr., Atlanta; George F. Klugh, Atlanta; J. P. Bowdoin, Atlanta; Wm. H. Hailey, Atlanta; and in closing by Dr. Yampolsky.

12. Dr. M. M. McCord, Rome, read a paper entitled "Report of 2,000 Infants Fed on Dry Milk," which was discussed by Drs. John M. Poer, West Point; R. L. Miller, Waynesboro; Henry C. Wheelchel, Douglas; Wm. A. Mulherin, Augusta; Thomas R. Gaines, Hartwell; Wm. L. Funkhouser, Atlanta; T. W. Ayers, University of China, Shantung, China; and in closing by Dr. McCord.

On motion the Association adjourned at 5:50 to reconvene at 7:45 P. M.

## FIRST DAY—EVENING SESSION

The Association reconvened at 8:17 P. M. and was called to order by the President, Dr. J. O. Elrod, Forsyth.

13. Dr. J. Calvin Weaver, Atlanta, presented a paper entitled, "Further Observations on the Management of Head Injuries," which was discussed by Dr. T. C. Davison, Atlanta, and in closing by the essayist.

14. Dr. H. H. Martin, Savannah, who was to have read a paper on "The Eye as an Index in the Study of Focal Infection," was unable to be present because of illness.

Dr. W. R. Dancy: Mr. President, I would like to state that Dr. Martin was stricken with an acute attack of appendicitis two days ago. He was operated upon and it will be impossible for him to be at the meeting. As you know, he has been a very active member of our Society and is one of the past presidents. If I am not out of order, Mr. President, I move that a telegram of sympathy be sent to Dr. Martin, expressing our regret at his illness and our hope for his speedy recovery.

Motion seconded and unanimously carried and the Secretary requested to attend to the matter.

15. Dr. Samuel J. Sinkoe, Atlanta, presented a paper entitled, "Diagnostic Importance of the Pyelogram in Chronic Abdominal Conditions." No discussion.

16. Dr. Charles E. Waits and Dr. R. F. Leadingham, Atlanta, presented a paper entitled, "Clinical and Pathological Observations on 100 Cases of Goiter," which was discussed by Dr. Stewart R. Roberts, Atlanta. In closing Dr. Waits exhibited some lantern slides and Dr. Leadingham demonstrated the pathological findings.

17. Dr. Charles E. Dowman and Dr. Floyd W. McRae, Atlanta, gave a demonstration of "Motion Pictures as a Valuable Aid in the Clinical Study of Cases and as a Method of Teaching." No discussion.

The Secretary announced the meeting of the Pediatric Section of the Fulton County Medical Society immediately following the adjournment of the general session.

On motion the Association adjourned at 10:15 P. M., to reconvene at 9:00 A. M. Thursday.

## THURSDAY, MAY 14, 1925

## SECOND DAY—MORNING SESSION

The Association met at 9:30 and was called to order by Ex-President, Dr. John W. Daniel, Savannah, as the House of Delegates was in session.

18. Dr. Jack W. Jones, Atlanta, presented a paper on "Dermatophytosis," which was discussed by Drs. Wm. H. Hailey, Atlanta; W. P. Jordan, Columbus; Moses G. Campbell, Atlanta, and in closing by the essayist.

19. Dr. J. A. Redfearn, Albany, read a paper on "The Treatment of Diabetes Melli-



tus," which was discussed by Drs. James E. Paullin, Jr., Atlanta; J. W. Daniel, Savannah; Hal McC. Davison, Atlanta; J. D. Gray, Augusta; Thos. E. Rogers, Macon; and in closing by the essayist.

The Secretary: If the gentleman who discussed Dr. Jones' paper, Dr. Hailey, Dr. Jordan, Dr. Campbell and Dr. Jones, will write out their discussions and send them in we will be glad to publish them in connection with the paper. Our reporter was busy with the meeting of the House of Delegates and was unable to be here on time.

The official picture of the Association will be taken on the terrace of the hotel immediately after the close of this session. Please go there direct from the session so that we may have a full representation of the Association. The photographer will be waiting there at 1 o'clock.

There will be a dinner of the Class of 1900 of the old Atlanta College of Physicians and Surgeons at 7:00 o'clock this evening at the Henry Grady Hotel.

There will be a special demonstration of endocrine cases in the Scientific Exhibit room this evening at 5:00 o'clock, or immediately after the close of the afternoon session.

The Secretary then presented a brief summary of the proceedings of the House of Delegates at its meeting that morning. (Cf. published report.)

Dr. R. L. Miller called special attention to the request that the incoming President should reappoint the Committee on Hospitals, with Dr. Cleveland Thompson and Dr. Harbin on the Committee, and moved the adoption of the report with the exception of the portion in regard to endorsing the bond issue for good roads in Georgia.

Motion seconded by Dr. John W. Daniel.

Discussed by Dr. McArthur, who strongly favored endorsing the bond issue; by Dr. Daniel, who favored good roads but was not in favor of a large bond issue—thought each county should build its own roads; by Dr. L. C. Allen, who agreed with Dr. Daniel that the people of Georgia would be wise in refusing to support a bond issue at this time, thought it was wise to go slowly in adding more burdens to the taxpayers; by Dr. E. C. Thrash, who thought it well to bring these matters up in the scientific session, and called for the question.

Dr. McArthur asked for a vote to determine whether or not the Association endorsed the bond issue.

Dr. Miller's motion that the report of the House of Delegates be ratified with the excep-

tion of the section regarding the bond issue of \$70,000.00 was put to a rising vote and lost. (Sixty-six in favor, sixty-seven against.)

Dr. Harvard moved the adoption of the report as presented.

Seconded by several, put to a rising vote and carried. (Seventy-seven in favor, seventy-four against.)

The President announced the result of the vote and stated that the report was adopted as read.

The President: Before proceeding with the program, gentlemen, I wish to introduce to you a very well-known man and an excellent speaker, who needs no introduction in Atlanta. Mr. W. Tom Winn of the Kiwanis Club of Atlanta will speak to us for a few moments on "Good Roads for Georgia." I am sure we will all enjoy hearing him. (Applause.)

Mr. Winn then delivered a brief address on the many advantages of good roads.

Vice-President Dr. Wm. A. Mulherin then took the Chair and the scientific program was resumed.

20. Dr. E. E. Murphy, Augusta, read a paper on "Chronic Adhesive Mediastino-Pericarditis, with Review of 150 Cases," which was discussed by Drs. V. P. Sydenstricker, Augusta; E. C. Thrash, Atlanta; Thos. E. Rogers, Macon; and in closing by Dr. Murphy.

21. Dr. E. C. Thrash, Atlanta, presented a paper entitled "Treatment of Pneumonia," which was discussed by Drs. R. L. Miller, Waynesboro; L. F. Lanier, Rocky Ford; Lewis D. Hoppe, Jr., Atlanta; Arch Elkin, Atlanta; W. T. Freeman, Atlanta; and in closing by Dr. Thrash.

Dr. Stewart Roberts asked for the privilege of the floor and stated that a representative of the Southern Medical Association was in the lobby and prepared to accept applications for membership in the Association. He further stated that the Southern Medical Association now had over eight thousand members, was second in size to any medical organization in the world, that Texas had the largest membership, Tennessee ranking second and Georgia third, and urged a larger membership from Georgia.

Dr. Mulherin: Gentlemen, the hour has now arrived for our President's address and I know we shall all be interested in what Dr. Elrod has prepared for us. (Applause.)

Dr. Elrod then delivered the Presidential Address which, in accordance with established custom, was not thrown open to discussion.

On motion the Association adjourned at 12:45 to reconvene at 2:30 P. M.



## SECOND DAY—AFTERNOON SESSION

The Association reconvened at 2:40 P. M., and was called to order by the President, Dr. J. O. Elrod, Forsyth.

22. Dr. E. B. Saye, Milledgeville, read a paper on "The Dextrose Content of the Cerebrospinal Fluid in Certain Nervous and Mental Diseases."

The President requested Dr. V. O. Harvard, Chairman of the Council, to take the Chair at this time as he had to attend a business meeting.

23. Dr. W. E. McCurry, Hartwell, read a paper entitled, "Hexylresorcinol in Bacillus Proteus Pyelitis with Report of a Case."

24. Dr. Walter R. Holmes, Atlanta, read a paper on "The Treatment of Pyelitis."

These two papers were then discussed by Drs. Thomas R. Gaines, Hartwell; C. H. Richardson, Jr., Macon; and in closing by Dr. McCurry.

25. Dr. W. F. Westmoreland, Atlanta, presented a paper on "The Surgery of Inguinal Hernia," which was discussed by Drs. G. Y. Massenburg, Macon; L. Sage Hardin, Atlanta; A. J. Mooney, Statesboro; and in closing by Dr. Westmoreland.

26. Dr. G. Y. Massenburg, Macon, presented a paper on "Local Anesthesia in Surgery," which was discussed by Drs. A. J. Mooney, Statesboro; Lon W. Grove, Atlanta; Charles K. Wall, Thomasville; and in closing by Dr. Massenburg.

27. Dr. W. H. Clark, LaGrange, presented a paper entitled, "History Taking by the General Practitioner."

28. Dr. Henry Livingston, Savannah, read a paper on "Syphilis and the General Practitioner," which was discussed by Drs. Wm. H. Myers, Savannah, and Joseph Yampolsky, Atlanta.

The Secretary announced an executive session of the Council immediately after adjournment.

On motion the Association adjourned at 5:30 P. M. to reconvene at 9:00 A. M. on Friday.

The banquets of the Association and of the Ladies Auxiliary were held on Thursday evening.

Following the doctors' banquet Dr. Edward Francis of the United States Public Health Service, Washington, D. C., delivered an address on "Tularemia," and Dr. W. S. Goldsmith, Atlanta, presented the "Badge of Service" to the President, Dr. J. O. Elrod.

Following the speeches there was some exhibition dancing and an informal dance for the members of the Association.

## FRIDAY, MAY 15, 1925

## THIRD DAY—MORNING SESSION

The Association met at 9:15 A. M. and was called to order by the President, Dr. J. O. Elrod, Forsyth.

29. Dr. Dan C. Elkin, Atlanta, presented a paper entitled, "Cancer of the Pancreas and Bile Ducts."

30. Dr. E. C. Davis, Atlanta, presented a paper entitled, "Malignant Conditions of the Cecum, Colon and Appendix, with Report of Cases."

The President extended the privilege of the floor to Dr. Walter E. Sistrunk of the Mayo Clinic and all the other guests, and requested Dr. Sistrunk to open the discussion on these papers.

These two papers were then discussed by Drs. Walter E. Sistrunk, Rochester, Minnesota; C. C. Harrold, Macon; Trimble C. Johnson, Atlanta; and in closing by Dr. Elkin and Dr. Davis.

The President then introduced Dr. George Pope Huguley, of Atlanta, who read a communication from Dr. Franklin H. Martin, Chicago, regarding the Gorgas Memorial.

No action was taken.

(Communication follows minutes.)

Dr. Walter E. Sistrunk, Rochester, Minnesota, then addressed the Association on "The Diagnosis of Abdominal Conditions."

This address was discussed by Drs. William P. Harbin, Rome; L. W. Grove, Atlanta; Edward C. Davis, Atlanta; Willis B. Jones, Atlanta; and in closing by Dr. Sistrunk.

31. Dr. Charles Usher, Savannah, read a paper on "Cysts of the Mesentery," which was discussed by Drs. J. L. Campbell, Atlanta; Thomas C. Davison, Atlanta; C. C. Harrold, Macon, and in closing by Dr. Usher.

32. Dr. C. McH. Cline, Atlanta, read a paper entitled, "Diagnosis and Treatment of Maxillary Sinusitis," which was discussed by Drs. Louis F. Lanier, Rocky Ford; James Lawton Hiers, Savannah; Henry R. Slack, LaGrange; Murdock E. Ecken, Atlanta; Wm. A. Mulherin, Augusta; R. L. Miller, Waynesboro; and in closing by Dr. Cline.

The President: The time has now come for our annual election of officers and I will request the Ex-Presidents in the audience to step forward and act as Tellers.

Dr. M. A. Clark, Dr. J. W. Palmer, Dr. E. C. Davis, Dr. E. E. Murphy and Dr. E. C. Thrash complied with this request.

The following officers were then balloted upon and declared duly elected for their respective periods:

For President, Dr. Frank K. Boland, Atlanta.

1st Vice-President, Dr. W. R. Daney, Savannah.

2nd Vice-President, Dr. H. M. Fullilove, Athens.

Secretary-Treasurer, Dr. Allen H. Bunce, Atlanta.

Parliamentarian, Dr. M. A. Clark, Macon.

Delegate to A. M. A., Dr. R. L. Miller, Waynesboro.

Alternate to A. M. A., Dr. C. W. Roberts, Atlanta.

#### *Councillors—*

Fifth District, Dr. E. C. Thrash, Atlanta.

Sixth District, Dr. M. M. Head, Zebulon.

Seventh District, Dr. M. M. McCord, Rome.

Eighth District, Dr. S. D. Brown, Royston.

Invitations were extended to the Association to meet in Albany and in Macon in 1926, and after some discussion it was moved and seconded that the invitation to meet in Albany be accepted.

The motion was put to a rising vote and carried and the President declared Albany to be the next meeting place.

The President then requested the Ex-Presidents to escort the newly elected officers to the platform, and introduced the new President, Dr. Frank K. Boland, in a few well chosen words. (Applause.)

In accepting the office, Dr. Boland said:

Dr. Elrod, and Fellow Members of the Medical Association of Georgia: At a time like this a man has a double feeling, one of exaltation and one of humility. My feeling of exaltation is no greater than my feeling of humility. It is a big job and will take a lot of time and responsibility and I can only succeed with your help. I do not remember ever being any more proud than at this moment, except when I led a beautiful and unsuspecting young lady up to the altar.

I bespeak your co-operation in every way. The retiring President tells me he has traveled three thousand miles in the last year. I may have to travel four thousand for this is a constantly growing job, but I will do my best in every way.

I wish to congratulate the retiring President, Secretary Bunce and Dr. Pruitt and all of the other officers on the splendid condition in which we find the Association. I realize that the President is only one of many who make for the success of the meeting. If I had been chosen on account of oratory I would not be here, but I feel that my honor comes from the loyalty of my friends and I wish to thank you from the bottom of my heart. (Applause.)

Dr. W. R. Daney: I deeply appreciate the honor which has been conferred upon me.

I do not know how or why I should have been connected with the word "Vice," and do not propose to say much about that term. (Laughter.) I learned a lesson from a bootlegger in Savannah on one occasion. I met this man one day and said to him, "I hear you are going to be indicted for liquor traffic," and he replied, "There's nothing to it." Two days later he was indicted and fined \$500.00. I asked him soon afterward how it happened and he said, "Well, what they told me they had on me wasn't much, but what I found they really had on me was a whole lot and I thought I'd better keep quiet." (Laughter.)

I appreciate this honor very deeply and pledge my hearty support in everything I can do to further the interests of the Medical Association of Georgia. (Applause.)

Dr. M. A. Clark: When you elected me to this office some time ago I did not doubt that I could burn the midnight oil and learn enough of parliamentary law to be able to serve you, but I did doubt my ability to be tactful and careful enough to do it. I have tried faithfully and your expression today tells me that I have done well. I thank you, and while I would enjoy being just a plain member for some years now since you think I can serve you I will give you the best I have as the years go by. (Applause.)

Dr. Marion C. Pruitt announced the Alumni Clinic week in Atlanta, June 8 to 12, and urged a full attendance.

On motion the Association adjourned at 1:40 to reconvene at 3:00 P. M.

#### THIRD DAY—AFTERNOON SESSION

The Association reconvened at 3:15 P. M. and was called to order by the President, Dr. Frank K. Boland, Atlanta.

Dr. J. O. Elrod: Mr. President, in view of the nice assembly hall and the courteous treatment accorded us by the management of the Atlanta-Biltmore while here, I move a rising vote of thanks to the hotel management for their courtesy and attention, and that the Secretary be instructed to convey our thanks to them in a suitable letter.

Motion seconded and unanimously carried.

Dr. Elrod: I also move a vote of thanks to the Fulton County Medical Society for the splendid hospitality and entertainment they have given us since we have been in Atlanta.

Motion seconded and unanimously carried.

Dr. Elrod: I wish to move a vote of thanks to the Fulton County Woman's Auxiliary, consisting of the wives of the doctors in Fulton County, and to the Atlanta ladies who assisted them, for their many courtesies to us during our sessions.

Motion seconded and unanimously carried.



Dr. M. A. Clark: You may all be interested to hear that the banquet had the largest attendance, and that we have the largest registration in the history of the Association. (Applause.)

The President: If there is no further business, gentlemen, we will now proceed with the first paper for the afternoon.

33. Dr. H. R. Donaldson, Atlanta, presented a paper entitled, "Some Views on Appendiceal Abscess."

34. Dr. W. W. Battey, Jr., Augusta, presented a paper entitled, "Appendicitis in Childhood."

These two papers were discussed by Drs. Louis F. Lanier, Rocky Ford; Wm. A. Mulherin, Augusta; Wm. A. Norton, Savannah; Charles Usher, Savannah; Edgar H. Greene, Atlanta; W. Duncan Owens, Atlanta; R. J. Alexander, Waco, Texas (by invitation); J. L. Campbell, Atlanta.

Dr. Bunce: The time has come when our official stenographer has to leave us, as she has to be in Fargo, North Dakota, Sunday evening, and I move a rising vote of thanks to Mrs. Irene Hilton Snyder for her very efficient services during the meeting.

Motion seconded and unanimously carried.

### THE GORGAS MEMORIAL

Gentlemen:

Since the last meeting of your Society the Gorgas program has evidenced a steady, healthy growth. Fifteen hundred well known doctors and influential laymen and women are now actively participating as State Governing Committee members in developing the movement. As you know, the Gorgas Memorial consists of two phases: first, research in tropical medicine; and second, a "personal" health educational campaign.

### THE RESEARCH PROGRAM.

Last September, the Republic of Panama authorized the floating of a \$750,000 bond issue to finance the construction of the Institute which will be erected on a site of land donated by the Panama Government. \$10,000 worth of material is now available for use when a sufficient sum has been realized from the Endowment Fund to finance the research teams. In addition a drive to raise \$10,000 towards the Endowment Fund is now under way in Panama and the Canal Zone. In other words, the Republic of Panama, in recognition of Gorgas' great work in that country, is evidencing its appreciation by making this very substantial contribution to the Memorial in his honor. No part of the funds raised in the United States will be used for building or

equipment as this is being provided for in the manner outlined above. Our only obligation is to maintain the building when it is built and finance the research workers.

### THE "PERSONAL" HEALTH CAMPAIGN.

Public health activities are adequately provided for in practically every State. But "personal" health depends upon the individual. Many diseases that are incurable in later life might have been checked if discovered in their incipiency. Many diseases are caused by faulty habits and might logically be termed "habit" diseases. This is the group that the Gorgas Memorial hopes to reduce by urging upon the individual the importance of keeping in close contact with his family doctor, consulting him frequently for advice in order to keep well and having a periodic health examination for the purpose of detecting physical defects and remedying them before they progress to the incurable stage.

The "personal" health campaign was begun in a modest way in January of this year. Twelve signed health articles prepared by doctors of national reputation (members of our State Governing Committees) have been distributed to 1,000 newspapers and the various press associations. A series of twelve radio talks have been broadcasted by State Governing Committee members from the principal radio stations of the United States. Arrangements have been made with several radio directors for the broadcasting of Gorgas health talks weekly.

In these articles and talks, the point is driven home to the reader or "listener-in" that his family physician should be regarded as the custodian of his physical well being and that the scientific medical profession is the real authority in all matters pertaining to health.

It gives us great pleasure to report that the response from newspaper editors and radio directors has been most cordial. Every article we have issued has been published and scores of editorials commenting favorably on this movement of doctors and laymen to make life healthier and longer by developing co-operation between the public and the scientific medical profession, have been received at headquarters. In this connection, the following quotation from the Detroit Saturday Night, a lay weekly, is pertinent as it is typical of editorial comments received from all sections of the country:

"Quacks and quackery will receive a heavy blow when the Gorgas Memorial Institute, re-



cently founded in honor of the great army medical man who showed the world that yellow fever and other pestilences could be conquered by preventive methods, gets functioning. The Institute is not heralding as one of its purposes the counteracting of propaganda such as is spread by Bernard MacFadden and others of his kind who use every opportunity to attack the medical profession, but just so far as its plans as announced are successful, *it will help to overcome pernicious teachings and ignorance regarding health.*"

To summarize, we feel that the Gorgas program has passed the experimental stage. The public is willing and anxious to be guided in matters of health by the real authority—the scientific medical profession. But the representative men in the profession must accept the responsibility their position places upon them. Public ignorance is encouraged by professional reticence. Every high-minded doctor abhors self aggrandizement and blatant self advertising. But the public is entitled to proper health information furnished them in a conservative ethical way from authoritative sources. This cannot be done by the individual physician. The Gorgas Memorial is the channel through which it can be done. To make it 100 per cent effective, we must have the support of every doctor.

In the very near future, intensive organization of the Georgia Gorgas Memorial Governing Board will begin. Your State should be adequately represented in order that the permanent activities of the Gorgas Memorial which will be supervised by the State Governing Board may be properly cared for. We sincerely trust that Georgia will play an active and influential part in the full development of the Gorgas Memorial.

FRANKLIN MARTIN, M.D.,

*Chairman of the Board, Gorgas Memorial Institute, 410 North Michigan Avenue, Chicago.*

## PROCEEDINGS OF THE HOUSE OF DELEGATES, . . . . .

**TUESDAY, MAY 12, 1925**

### FIRST MEETING

The House of Delegates was called to order at the Atlanta-Biltmore, Atlanta, at 8:15 P. M., by the President, Dr. J. O. Elrod, Forsyth.

The President: Gentlemen, this is an Executive Session of the House of Delegates and the only ones who are permitted to be present are the Delegates, the Councillors and the Vice-Presidents. Chairmen of committees may be present to give their reports, and ex-presidents.

### ROLL CALL:

The Secretary: I will request each member to rise and give his name and the County Society he represents, and then turn in a card containing this information.

The following gentlemen responded:

Dr. B. C. Teasley, Hart County.

Dr. J. L. Garrard, Floyd County.

Dr. John W. Daniel, Chatham County (Ex-President).

Dr. A. J. Waring, Chatham County.

Dr. Cliff Moore, Floyd County.

Dr. M. M. McCord, Councillor, 7th District.

Dr. J. H. Grubbs, Pike County.

Dr. W. C. Lyle, Councillor, 5th District.

Dr. C. E. Waits, Fulton County.

Dr. W. E. Person, Fulton County.

Dr. L. L. Whiddon, Irwin County.

Dr. A. J. Mooney, Bulloch-Candler Counties.

Dr. C. W. Strickler, Fulton County.

Dr. A. F. White, Butts County.

Dr. C. W. Roberts, Chairman, Com. Public Policy and Legislation.

Dr. Ralph Freeman, Jackson County.

Dr. Warren A. Coleman, Ocmulgee Soc., Dodge, Bleckley, Pulaski.

Dr. J. L. Campbell, Fulton County.

Dr. J. G. Dean, Terrell County.

Dr. O. W. Roberts, Councillor, 4th District.

Dr. J. M. Kenyon, Stewart-Webster Counties.

Dr. W. A. Selman, Fulton County.

Dr. Claude Griffin, Carroll County.

Dr. V. O. Harvard, Crisp County, Councillor 3rd District.

Dr. W. F. Reavis, Ware County.

Dr. C. K. Sharp, Tri-County, Councillor 2nd District.

Dr. E. C. Thrash, Ex-President.

Dr. C. Thompson, Jenkins County.

Dr. E. H. Richardson, Polk County.

Dr. J. W. Palmer, Ex-President.

Dr. B. H. Wagnon, Fulton County.

Dr. F. B. Blackmar, Muscogee.

Dr. W. A. Mulherin, Richmond County.

### REPORTS OF OFFICERS:

*President's Report:* Dr. Elrod requested Vice-President Dr. B. H. Wagnon, Atlanta, to take the Chair, and then made the following report:

In the past your President has not been asked for a report, but I wish to state that I have traveled over the State about 3,200 miles, visiting District and County societies. I have attended eight District Societies, including two, the eleventh and twelfth, as guests of the District of Savannah. I would

have gone to the Twelfth District but the Twelfth District has not had a meeting this year, and for that reason I did not attend that Society. I failed to attend the meetings of the Third District Society because at the time of their first meeting I had a patient who was taken suddenly ill the night before and I could not get there. I had all my arrangements made to go to the next meeting, but very much to my surprise I had an acute appendix of my own, and as the Society meeting was opened at 3 o'clock, Dr. Rozar opened my abdomen, so I was prevented from attending both meetings of the Third District. We have had a splendid attendance at the District meetings.

During the year I appointed twenty-four examiners to examine the teachers for the different summer schools, and also twenty-four lecturers to lecture to the teachers in the different districts in Georgia.

This, I think, covers the work I have done during the year. It has been a pleasure to attend the District Societies for they have had really good meetings. We have carried on as much work with the County Societies and have a better membership than usual. The Secretary will tell you in his report about the membership we have at present.

Dr. E. C. Thrash: I move that we accept the report, thank the President for the services he has rendered, and extend to him the statement, "Well done, thou good and faithful servant."

Motion seconded and unanimously carried. President Elrod then resumed the Chair.

*Parliamentarian's Report:* Dr. M. A. Clark.

I did not know that the Parliamentarian had to make a report. You are constantly hearing from me from time to time and I think you had better make a report on me. When you elected me to this office I tried to prepare myself so that I might serve you well. I have not read every word in all the Manuals, but in my reading I have found that it is very wise that we should have rules to govern deliberative bodies. If we have not some rules for controlling them it is hard to get things done in decency and order. If rules are properly carried out it facilitates this very greatly. The chief object in having parliamentary laws is to try to get things in the right form, and your Parliamentarian is trying to do this. He has studied these things and tried to give them to you as they are written.

In making my report I wish to thank you for your kindness and forbearance. You have been very considerate and even in my blunders you have not called me to task much.

Dr. Thrash: I move that we accept this report of Dr. Clark's. We have no doubt of his knowledge of parliamentary usage and our only doubt is that we may be wrong ourselves.

Motion seconded and unanimously carried.

DR. ALLEN H. BUNCE.

## REPORT OF SECRETARY-TREASURER

### Membership

The Association has 1,537 paid up members as compared with 1,421 at the beginning of the annual meeting last year. However, the meeting date is one week later this year but there are actually nearly a hundred fewer active doctors in Georgia now than in 1924. Therefore, there is an actual increase in the percentage of members of the Association.

### County Societies

At the beginning of the annual meeting last year we had received reports from ninety constituent county societies. This was increased to one hundred by December 15th. Up to the present time this year we have already received reports from one hundred county societies. The fundamental thing on which the Association must build its entire structure is the live active county society. Therefore, it would seem that every effort should be exerted to keep as many county societies alive as possible. The constituent society is the unit on which the Association rests.

### The Journal

The Journal has been increased from sixty-four to sixty-eight pages, thereby adding a cover and giving room for additional material. It is published on a good quality of paper and there has been a noticeable improvement in the quality and quantity of manuscript submitted for publication. The Publication Committee, appointed by the Chairman of the Council, Dr. V. O. Harvard, has given serious thought to the character and scope of your Journal. Its policies and recommendations will be presented to you by its Chairman, Dr. Charles Usher. Your Editor is under great obligations to the members of this Committee for their helpful and constructive work and loyal support.

The Business Manager of the Journal, Dr. M. C. Pruitt, has continued his energetic, faithful and economic management. He has had entire charge of the advertising department of the Journal and exhibitors at each annual meeting. The Journal itself is a silent testimony to his efficiency. We are



deeply indebted to him for this part of the Association's success.

### A Full Time Executive Secretary

During the year the Council authorized your Secretary-Treasurer to rent a separate room for the headquarters of the Association and to employ a full time Executive Secretary. Miss Martha Irwin has filled this position to the full satisfaction of all. She has shown a sincere interest in her work and is fast becoming invaluable to the Association.

### Renewal of Charter

As instructed by the House of Delegates last year the Charter of the Association has been renewed for twenty years.

### Committees

Your Committees—both standing and special—have held numerous meetings and have served the Association well. Their reports will be presented to you by their Chairmen.

### Financial Report

On May 1, 1924 we had \$6,609.88 in the Bank and all current bills paid. On May 1, 1925 we had \$7,182.68 in the Bank and all current bills paid. A detailed financial report has been submitted to the Council for its audit. Notwithstanding this increase in our assets it will be necessary for us to exercise the strictest economy in order to continue all the activities of the Association which have been directed by the House of Delegates and Council.

### Conclusion

In conclusion, I wish to express to you my sincere appreciation of the confidence you have placed in me and the loyal support you have given me in the discharge of my duties as your Secretary-Treasurer and Editor. The President of the Association, Dr. Elrod, the Chairman of the Council, Dr. Harvard, the members of the Council and members of Committees have all served the Association faithfully and well and have rendered me every assistance possible. We owe a debt of gratitude to the secretaries of all constituent societies for their helpful cooperation and invaluable aid.

Respectfully submitted,

ALLEN H. BUNCE, M.D.,  
Secretary-Treasurer.

May 12, 1925

On motion of Dr. Thrash, duly seconded and carried, this report was accepted as read.

## REPORT OF THE COUNCIL

To the House of Delegates:

Since the annual meeting of the Association last year, the Council has had two meetings. The first was held at the DeSoto Hotel in Savannah on July 16, 1924, during the meeting of the First District Medical Society. Eight Councillors, together with the President, Secretary-Treasurer and Second Vice-President of the Association, were present. The fourth, fifth, seventh and eighth districts were not represented.

The Council considered the resolution introduced by the Committee on Public Policy and Legislation before the House of Delegates at the Augusta, 1924 meeting of the Association, which resolution was referred to the Council. It was in reference to the employment of a full time executive secretary. After due deliberation the Council decided it unwise to recommend any change at this time and decided such would be its report to you at this time.

The Council next authorized the Secretary-Treasurer to rent a separate office for the Association at an expense not to exceed \$21.50 per month. He was also instructed to employ a stenographer and bookkeeper who should have charge of this office under his supervision at a salary not to exceed \$100.00 per month.

The second meeting of the Council was held at the Dempsey Hotel in Macon on April 14th of this year. All districts were represented with the single exception of the eleventh. Dr. J. W. Simmons, Councillor from this district, found that he was unable to attend to the duties pertaining to the Association and sent in his resignation. The President appointed Dr. A. S. M. Coleman, of Douglas, to succeed Dr. Simmons. Subsequently, Dr. Coleman appointed Dr. Kenneth McCullough, of Waycross, as his Vice-Councillor. In addition to the members of the Council, the President, Parliamentarian and Secretary-Treasurer were present.

An appeal by a former member of the Association from the decision of his county society was heard, but definite action postponed.

Complaints were received from many members in reference to their county secretaries not sending in their dues promptly and, thereby, delaying the receipt of cards by such members. The Council earnestly suggests that the secretaries of constituent societies send in the dues of members as soon as they are collected. Thus membership cards can be issued promptly and confusion avoided. Annual dues are payable on January first of each year. A period of three months grace—up to April first—is



allowed by our Constitution and By-Laws to help prevent members from becoming delinquent and to help keep them in good standing so that they may receive all the benefits of membership.

The Council directed me to call your attention again to the fact that all members of county societies must pay dues to the State Association. No county society may accept a member and allow him to pay dues to the county society and not to the State Association. All county societies are constituent parts of the Medical Association of Georgia, hold charters from the Association, and must conform to its Constitution and By-Laws.

At the second meeting of the Council, the Secretary-Treasurer gave a detailed report of the status of every county society in the state as compared with the same time last year. Two districts, the second and seventh showed gains at that time.

The Council authorized the Secretary-Treasurer to increase the salary of the stenographer and bookkeeper for the Association, Miss Martha Irwin, to \$125.00 per month. Upon the suggestion of the President, Dr. Elrod, she was given the title of Executive Secretary.

We are glad to report that we now have the largest paid up membership in the history of the Association at any annual meeting. The members of your Council have served faithfully and well and have been ably assisted by all officers of the Association. The secretaries of the county societies deserve our special thanks and we gladly acknowledge our debt of gratitude to them.

Respectfully submitted,

V. O. HARVARD, M.D.,  
Chairman, Council.

Atlanta, Ga., May 12, 1925

Dr. Palmer: I move that the report be accepted as read.

Motion seconded.

Dr. Thrash: I would like to ask what action was taken on the appeal mentioned.

Dr. Harvard: That matter is under consideration by a committee and is to be reported on at the next meeting of the Council.

Dr. Palmer's motion was put to a vote and carried.

## REPORTS OF COMMITTEES:

### REPORT OF THE COMMITTEE ON SCIENTIFIC WORK

The Committee on Scientific Work held its first meeting in the DeSoto Hotel, Savannah, Georgia, July 16, 1924, at 1 o'clock p.m.

All members were present. The following report, which was published in the January, 1925 issue of the Journal, was adopted:

1. Any member of the Association in good standing may send in a title for the program.

2. All titles must be sent in in writing on or before March 15th. They may be sent to the Secretary-Treasurer or to either of the members of this Committee. (By-Laws, Chap. VI, Sec. 2.)

3. By-Laws, Chapter VIII: "Sec. 1. No address or paper before the Association shall occupy more than fifteen minutes in its delivery; and no member shall speak longer than five minutes, nor more than once on any subject, except by unanimous consent.

"Sec. 2. All papers read before the Association, or any of the sections shall become its property. Each paper shall be deposited with the Secretary-Treasurer when read."

4. Resolution adopted 1921: "Resolved, That a member who sends in a title of a paper to be placed on the program and is not present to read the paper shall pay the penalty of not having the opportunity to appear on the program for two years, unless he presents an excuse acceptable to the Committee on Scientific Work."

5. All papers must be typewritten, double-spaced and on one side of the paper. Each paper should bear name and address of author and should be correct from the standpoint of spelling, grammar, rhetoric, etc.

6. No member will be placed on the program whose dues for the current year have not been paid.

7. Other things being equal, preference will be given to those who were not on the program last year.

At the second meeting of the Committee, which was held March 22, 1925, at the office of the Association, 65 Forrest Avenue, Atlanta, Georgia, the following members were present: Drs. A. R. Rozar, Chairman, Macon; Hugh N. Page, Augusta, and Allen H. Buncie, Secretary-Treasurer. Dr. J. O. Elrod, President, Forsyth, was also present.

Every title received was carefully considered and we attempted so far as possible to see that every section in the State was represented, preference being given always to men in the smaller communities. Thirty-six titles were selected. The ones selected are those that appear on the official program, which we submit as our report.

The Committee suggests that the Councilor from each District make it a part of his duty to see that his District is represented on the program. There should be at least two papers from each District. This year there was one District not represented.

The Committee invited two guests, as provided in the Constitution and By-Laws.

1. Dr. Edward Francis, Surgeon, U. S. P. H. S., Washington, D. C., who will deliver a lecture on "Tularaemia," at the annual banquet, Thursday night.

2. Dr. Walter E. Sistrunk, of the Mayo Clinic, who will read a paper Friday morning on "Surgery of the Colon".

Since the U. S. P. H. S. has no fund to pay the traveling expenses of Dr. Francis, we recommend that the Association pay all of his expenses. We further recommend that the Association pay the hotel bill of Dr. Sistrunk and also his traveling expenses, provided it is not customary for them to be paid by the Mayo Clinic.

Respectfully submitted,

COMMITTEE ON SCIENTIFIC WORK,  
A. R. Rozar, M.D., Chmn.  
Hugh N. Page.  
Allen H. Bunce, Sec.-Treas.

Dr. Thrash: I move the adoption of this report.

Motion seconded.

Dr. Clark: The report recommends the expenditure of money and that must go to the business part of the Association before you can adopt. When you adopt this report it becomes your order of business. From time to time in the meetings of the Association a request comes to the President to allow some representative of some organization to appear before the body for a few minutes during the session. If in your wisdom you think it well to extend these courtesies I would suggest that you adopt this report as the official order of business, providing that the President in his judgment may allow this.

Dr. Thrash: I accept this amendment and move the adoption of the motion as amended.  
Motion seconded.

Dr. Person: We have a gentleman here in Atlanta who has been known as a scientific investigator for thirty-five years, and who claims that he has done some original work on cancer. Dr. F. H. Harris wants five minutes to exhibit a few patients tomorrow night so that he can get a little official recognition. I have not seen the work, but think you all know Dr. Harris.

Dr. Clark: I would not have made that recommendation if I had known this before. We have a Committee on Scientific Work to

thrash out the things that shall appear before the Association. You have a provision that titles of papers shall be submitted in advance in order that this Committee may study them and make their report which can be published. My recommendation was not in reference to scientific men. It is not wise to come before this meeting and bring up such conditions.

Dr. Thrash: I now move that we adopt this report with Dr. Clark's amendment and refer Dr. Person's suggestion to the Committee on Scientific Work. (Motion seconded.)

Dr. Person: If the Committee approves then could Dr. Harris present his work?

The President: Is he a member of the County Society?

Dr. Person: I think he is not in active practice at all but is devoting his time to original research.

The President: Then we could not recognize him. We will now vote on Dr. Thrash's motion.

Motion voted and unanimously carried.

## REPORT OF COMMITTEE ON PUBLIC POLICY AND LEGISLATION

To the President and House of Delegates,  
Medical Association of Georgia:

Your Committee was active during the session of the General Assembly of 1924, but failed in the accomplishment of any worth while legislation:

We gave our efforts to the following matters:

We deemed of special importance the securing of an increased appropriation for the State Board of Health and championed a bill to impose a tax of 10% on moving picture admission up to and including fifty cents. The bill was given a favorable recommendation by the Committee on Ways and Means, but later lost by reconsideration. Efforts in other directions to secure an increased appropriation for the State Board of Health failed due to lack of concerted action and lateness of effort.

These efforts took into consideration the resolution offered and approved by the 1924 House of Delegates in Augusta of Dr. Frank K. Boland asking for a per capita tax of \$1.00 to be known as the Sanitary Tax to be expended by the State Board of Health and a bill of similar nature which sought to tax on a per capita basis all the citizens of the State, to be paid out of the General Fund, after a sliding scale plan, beginning at 6 cents and running to 12 cents per capita. All plans failed because of lack of united effort behind some definite legislation program.



A bill known as the Lye Bill, sponsored by the Georgia Pediatric Society and approved by the 1924 House of Delegates and on resolution of its President Dr. A. J. Waring, to safeguard the distribution and sale of caustics and corrosive acids was framed and placed in the hands of a member of the House but was never introduced.

Your Committee had a meeting July 29, 1924 in an effort to muster strength and wider legislation support, but the results were disappointing. We learned by the experience of dealing with the 1924 session of the General Assembly that helpful and needed legislation could not be gotten by an eleventh hour effort nor without the support of physicians throughout the State.

We then resolved to set a program in operation and solicit the united support of the Medical Association of Georgia early enough in 1925 to get up a winning head of steam before the convening of the 1925 session. Since two years will elapse before we have another chance, it is important that we secure your active approval and more active support of the following program considered in the second meeting of your Committee detailed below:

1st. That we seek by addresses before Medical Societies, through timely articles in State Journal, and by personal appeal, to awaken the doctors of Georgia to their responsibility for the present defects in laws governing medical practice and bearing on matters of public health, as well as the advocacy and enactment of improved laws to secure the ends desired by our Association.

2nd. That in view of the fact that the Georgia State Board of Health is engaged in educational methods, seeking to teach our people how to get well from certain endemic diseases (malaria, hookworm, typhoid, etc.) as well as how to prevent the contraction of these and other contagious maladies, that we lend, first, the full measure of our co-operation and effort to the end that a more adequate appropriation for health work in Georgia be secured. North Carolina appropriates for the improvement of health conditions in the State, seventeen cents per capita, South Carolina, thirteen cents, Florida, twenty-five cents, as compared with the pitiful sum of three cents per capita in Georgia. Your Committee believes the doctors of Georgia should be able to convince the thoughtful leaders in the general assembly of the State of the unfairness which exists at the present time concerning appropriations made to other departments of the State government when compared to the inadequate appropriations

made to provide for the development of health work in Georgia.

3rd. That since we believe that certain laws have been enacted in Georgia which do not bear the approval of the profession at large, and that such laws would have been vigorously fought and likely defeated had the profession been given earlier information acquainting them with their provisions, that we establish a system whereby the profession may be promptly advised concerning legislation bearing on medical matters as soon as such bills are offered to the General Assembly.

4th. That in view of the fact that Georgia is rapidly developing industrially and has at this time a peculiar, and we believe rare opportunity for industrial growth, which has been, and is now, being hampered by crude health protection to the industrial workers of Georgia, that we recommend the appointment and approval by the House of Delegates of a special commission to be known as the Commission on Industrial Relations. This Commission to function by co-operating with the Department of Commerce and Labor and Public Health Agencies, approved by or bearing the approval of the Medical Association of Georgia, in the establishment of a bureau where complaints of prospective manufacturers and investors in Georgia industries may be registered, correct and adequate data formulated bearing on the actual conditions which now exist in the State and where any new moves looking forward to the improvement of working conditions and health of industrial employees may be initiated and developed.

5th. That adequate and practical information bearing on the medical phase of the Georgia Workmen's Compensation Laws be furnished the profession, believing as we do that the successful operation of the law in spirit and in letter requires the intelligent co-operation of the members of the Medical Association of Georgia.

6th. That as an earnest effort of our recognition of the first duty of our profession, namely to prevent disease, that we advocate state wide yearly examination of apparently healthy persons under rules and regulations to be formulated by our Association which will enable every one, regardless of his station in life, to secure the examination. In this wise we believe our profession will best serve the interest of Georgia's citizen by the discovery of and correction of incipient conditions, which, according to information from many sources and notably from the great war, has shown a high proportion of our citizens to be suffering from, although for the moment being borne without gross evidence of disease.



7th. That in keeping with the idea of educating our people in health matters, and to encourage recent graduates in medicine to locate for practice in rural communities, and in order to furnish institutions in which our citizens may be scientifically treated, that we advocate the encouragement of hospitals now established and the building of others by appropriation from the State when such appropriations are met by equal monies derived from the local or adjacent governments in which the hospital is situated. This scheme would call for a re-districting of the State in a manner which would give hospital service in every section of our State.

8th. That we urge the working out of plans whereby the whole State may be brought under the provisions of the Ellis Health Law.

**MINUTES OF THE FIRST MEETING OF  
THE COMMITTEE ON PUBLIC POLICY  
AND LEGISLATION OF THE MEDICAL  
ASSOCIATION OF GEORGIA,  
2 P.M., APRIL 14, 1925**

A meeting of the above committee was called to meet at the Academy of Medicine, 32 Howard Street, Atlanta, at 2 p.m., April 14, 1925, for the purpose of considering a program for the activities of the committee for the year 1925 and such other matters as might be brought before it by members or invited guests interested in matters of Medical Legislation or Public Health in Georgia. Those invited were as follows:

Dr. J. O. Elrod, Forsyth, President Medical Association of Georgia.

Dr. J. W. Palmer, Ailey, President, State Board of Medical Examiners and Member of Committee on Public Policy and Legislation.

Dr. A. H. Bunce, Atlanta, Secretary-Treasurer, Medical Association of Georgia.

Dr. T. F. Abercrombie, Commissioner of Health, State of Georgia.

Dr. John W. Daniel, Savannah, Member State Board of Health.

Dr. C. T. Nolan, Marietta, Secretary-Treasurer, State Board of Medical Examiners.

Dr. Theo. Toepel, Atlanta, Chairman, Committee on Health and Public Instruction.

Dr. C. E. Waits, Atlanta, Chairman, Committee on Public Policy and Legislation, Fulton County Medical Society.

Dr. W. E. McCurry, Hartwell, Member Committee on Public Policy and Legislation.

Dr. C. W. Roberts, Atlanta, Chairman, Committee on Public Policy and Legislation, State of Georgia.

As may be observed by the above invited physicians, your committee was seeking advice and council, desiring to secure approval of and concerted action in the carrying out of a program concerning Public Policy and

Legislation. The following business was transacted.

On motion of Dr. Palmer, seconded by Dr. Toepel, the chairman was requested to read the suggested program for the activities of the committee which had been prepared. Following the reading of this program and on motion of Dr. Palmer, again seconded by Dr. Toepel, the program as prepared was read in sections and finally on motion of Dr. Waits, seconded by Dr. Toepel, unanimously adopted.

It having developed under later discussion that certain changes in the bill creating the State Board of Health were desirable, a motion prevailed by Dr. Waits, seconded by Dr. Toepel, that the law recently enacted placing on the Board of Health two dentists, be repealed and that the President of the State Dental Association and the President of the State Medical Association be made ex-officio members at large during the term of office of the State Board of Health. Approved.

There being unanimous agreement, after free discussion, that the State Board of Health, represented the most important link between our Association and the people of the State with reference to the Application of Health Work, on motion of Dr. Palmer, seconded by Dr. Toepel, it was ordered that we earnestly solicit the hearty co-operation of all members of the State Association in securing an amendment to the Constitution of State to immediately provide a per capita tax of 6 cents, to be expended by the State Board of Health in the expansion of its State Wide Program. In view of the fact that an increasing revenue is necessary for the continued growth of the State Board's activities, unanimous approval was given to the request for a sliding of revenue, beginning at 6 cents per capita and increasing to 12 cents. The details of the bill to be formulated under the direction of the Commissioner of Health of Georgia. Approved.

On motion of Dr. Daniel, seconded by Dr. Palmer, a resolution was offered asking the general assembly to appropriate from the income from the tobacco tax an annual maintenance fund for the State Tubercular Sanatorium of \$250,000, and that we request the appropriation from the general fund of the State an annual appropriation of \$75,000 for the Institution at Gracewood for the treatment and re-education of Georgia's feeble-minded. Approved.

On motion of Dr. Waits, with proper second, a motion prevailed that the Chairman of the Committee on Public Policy and Legislation furnish through the State Journal

and otherwise at his option to the profession of the State information bearing on medical phases of the Workmen's Compensation Law as it affects the members of our Association. Approved.

On motion of Dr. Toepel, seconded by Dr. Palmer, Dr. Abercrombie, Commissioner of Health of Georgia, was requested to offer suggestions for the improvement of the Ellis Health Law, it having developed in discussion that its practical application in the State was being hampered by certain objectionable features.

On motion of Dr. Toepel, seconded by Dr. Palmer, it having developed in the discussion that physicians appointed to official positions in the State of Georgia by our Governor and others in authority should be approved by the Medical Association of Georgia or its component societies. Your committee went on record as requesting that our society be conferred with before such appointments are made. Approved.

On motion of the chairman, seconded by Dr. Palmer, the committee unanimously approved the putting into operation in Georgia of the Sheppard-Towner Bill. Approved.

Bearing on the matter of the establishing of a bureau for the dissemination of information concerning proposed legislation of interest to physicians in Georgia, Dr. Waits made a motion which was properly seconded, that the chairman of the committee be authorized to offer a proposed scheme for the organization of this bureau.

Finally, it having been brought to the attention of the meeting that the Vital Statistic Bill was in danger of being nullified by opinions of the courts of Georgia, a motion prevailed that in such event any amendments be made to the bill which might be required to keep it effective. Approved.

Dr. Roberts: Regarding the Ellis Health Law, Dr. Abercrombie reported to me today that after having taken this matter up with his health officers in the various counties throughout the State they had decided not to make any requests for changes in the law at present. They believe that if sufficient funds are given to the State Board of Health, if they are encouraged to put in the things that are best for the counties, the law will function and no change will be requested in the Ellis Health Law at this time.

With respect to what your Committee has been pleased to call the Bureau of Information, the purpose of such a Bureau would be to give red hot legislative information to the members of the Medical Association of Georgia

right off the bat. In other words, it is the belief of your Committee after the study we have made of the public health affairs in Georgia that our membership was not being interested in legislation in Georgia until the writing of laws which might or might not affect our status in the State. We believe that if such information was given to the Medical Association of Georgia from such a Bureau while it is being discussed and considered over at the Capitol, before it ever comes to a vote, that our membership might be able to exert whatever legislative power they possess. This is true in regard to any kind of legislation in the Assembly. Those of you who have been on committees know that it requires more than a report of what you have done and propose to do. It requires a certain amount of activity over at the Capitol, and that kind of activity is not such that always graces a medical man. You have to fight the devil with his own weapons, and the Committee believes that if the members of the Medical Association of Georgia think it worth while to establish such a Bureau, and put in a man who could do high and low-class lobbying for us and seek information as to how to proceed to accomplish things, that we may accomplish some real legislation in Georgia. I have found that other organizations of various kinds in Georgia who wish to have measures passed have employed certain men, whether they be attorneys or not, to get into communication with the proper people, and therefore your Committee thought wise to bring to your attention the necessity of the organization of such a Bureau. The organization on paper will not accomplish anything. It will be necessary for your organization to empower such a Committee to expend a certain amount of money. I am not sure of the amounts, but I have been reliably informed that \$1,000.00 is the usual retainer fee that a good man gets for this sort of work. If we mean to accomplish anything in medical legislation now or at any other time we have to change our method of procedure and do it as the other fellow does.

Permit me to conclude by stating that this all sounds like a pretty resolute program for our State Association. I believe the doctors of Georgia have come to believe that we have to get into politics if we are to accomplish anything. If we do not do this we might about as well abolish the Committee on Public Policy and Legislation. We have a session of the Legislature now and another in two years. We must act quickly. It requires two things: the political influence of every single solitary one of the members of



the Medical Association of Georgia. We have never had that before. The membership has never rallied to the support of legislation. We have to have it if we are to accomplish anything. The other thing is that we cannot accomplish anything if we do not expend a little money. The members of your Committee have to make a living the same as the rest of you, and we have to have some key man to be on hand to do the work, and that will require a little money. I thank you.

Dr. Thrash: This report is too comprehensive for us to comprehend by hearing it read.

I move that Dr. Clark be appointed to act with this Committee to bring back a concise report that we can all understand on Thursday morning.

Motion seconded.

Dr. Daniel: I think this motion is very bad and rather inopportune. I think it is too bad to introduce any other motions regarding legislative matters in Georgia. We are simply postponing things. We have a competent Committee and they have given it twelve months' consideration. They have brought in a very comprehensive report and the time is ripe to do something if we are ever going to do it. If we take the matter out of the hands of this Committee and put it in the hands of a substitute committee we can accomplish nothing. As a member of the State Board of Health and the Legislative Committee of that body I wish to say that the Bankers' Association and others are ready to follow us and if we take a step forward they will not only follow us, but I am sure if we approach them they will give us assistance in putting the thing over. They realize that without help we cannot do anything. They know that health is absolutely essential for efficiency and efficiency is necessary for money. The banker realizes that he cannot stay in business unless he has money and they are ready to help us if we go and ask them. If we adopt Dr. Thrash's motion we simply postpone things. The Legislature will meet and, as usual, we will do nothing.

As a substitute for Dr. Thrash's motion I move the adoption of this Committee's report, and hope that it will pass.

Motion seconded.

Dr. Thrash: My idea in my motion is to put the report in a concise way and adopt it by sections. We do not know what it is all about but if it is put in a concise manner on Thursday morning we can adopt it by sections as we may desire.

Dr. Clark: I would like to ask the Chairman if the committee he recommends entails any expenditure of money.

Dr. Roberts: None.

Dr. Clark: Your Bureau does. That part will have to go to the Council before you can act upon it.

Dr. Daniel: I wish to ask for information. Is it possible for the House of Delegates to adopt a resolution and recommend to the Council that they approve? I do not see anything out of order about that.

Dr. Clark: Read Article X of the Constitution, "Funds and Expenses."

Dr. Daniel: What is the President's idea of my point of information? Have we the right to approve this report and request the Council to approve it? We are simply asking them to approve the expenditure.

The President: I would have to rule that the Council would have to recommend this before the House of Delegates could do anything.

Dr. Daniel: I wish to know whether there is anything out of order in asking the Council for their approval of this matter. It is my idea to refer it with the request that they will approve the expenditure necessary.

Dr. Clark: That is an effort to instruct the Council before they act. You have wisely made your Council the finance committee of the Association and have provided that before any funds can be acted upon they must be approved by the Council. If you go and tell the Council that they must recommend a certain thing that surely is a violation of the spirit of the law. The object of the rule is for the Council to see that we have the funds or have means of getting them and then report back to the House of Delegates. It seems to me it would not be wise to do such a thing.

Dr. Thrash: My motion was to refer the report back to the Committee, with Dr. Clark on the Committee, to report back to us.

Dr. Miller: I think Dr. Clark does not understand Dr. Daniel. His motion is to refer the expenditure of this money to the Council with recommendation that they approve it.

Dr. Clark: According to the Constitution this does not need a motion.

The President: I rule that the Committee's report going to the Council will be the same as this motion.

Dr. Daniel: My motion was the adoption of the report just as it was read. My other remark was merely for information.

Dr. Lyle: There has been a motion, duly seconded, for the adoption of this report. It has been very comprehensive, very elaborate, and shows evidence of a great deal of study. Doubtless the Committee has felt that it was a wise thing to do. I am not sure that the House of Delegates is in a position at this time to refer one other recommendation to



the Committee, and that is the Shepard-Towner bill. I doubt if many of the delegates know anything about the real condition of the Shepard-Towner bill. Some of the State associations have adopted that bill and have rescinded it. The American Medical Association is by no means in favor of it. I think at least before the House of Delegates is asked to adopt that report *in toto* they should have some enlightenment on the Shepard-Towner bill.

Dr. Reavis: I wish to amend Dr. Thrash's motion, since hearing the discussion by Dr. Lyle. I was much impressed with the fact that the report is a good report in the respect that the members of the Committee have made quite a study of it. There are probably one or two members of the House of Delegates who would be opposed to having a paid representative to represent us in the Legislature. As Dr. Roberts said, we must whip the devil with the devil. There is a certain amount of sentiment back of this that we would all like to study further.

I offer this amendment to Dr. Thrash's motion, that the adoption of this program as outlined by Dr. Thrash be postponed until Thursday morning to give this body an opportunity to study the thing.

Amendment seconded.

Dr. Clark: I am glad that Dr. Lyle mentioned the Shepard-Towner bill. I am prepared to vote "No" on it. It is too serious a matter for you to act upon without giving it further consideration. I think the Committee is fully competent, but I believe the motion that it be postponed until we have time to study it further is a good one. I do not think it is necessary for me to be on the Committee but I think we should all get wise about the Shepard-Towner bill before we adopt or reject it. I believe there is no difference in the motion.

Dr. Thrash: I accept the amendment. There is no difference except that Dr. Clark be on the Committee and that the report be brought back in a concise way, and that we vote on it section by section as we see fit.

Dr. Clark: I wish to urge you not to adopt this report now, but to give it full consideration.

Dr. Palmer: I think we should have this report brought in by sections. As a member of the Committee I am sure we would be delighted to have the matter put off for further consideration and then take it up by sections so that intelligent action may be taken.

Dr. Daniel: I wish a point of information. Did not Dr. Thrash move that the matter be referred to another committee with Dr. Clark

as a member? If Dr. Thrash will withdraw that motion I will agree that we take the report up *scriptum* on Thursday morning.

Dr. Thrash: That is perfectly agreeable, but I think Dr. Clark should be a part of the conference.

Dr. Mulherin: About the Shepard-Towner bill, I wish to offer this as information. Dr. Lyle is correct in saying that the American Medical Association does not approve of the Shepard-Towner bill, but the Pediatric Section went on record as approving and they got a calling down from the American Medical Association. The sentiment in the Section is in favor of the Shepard-Towner bill. The opposition is that it came from Europe and that there is an element of paternalism in it. I think we should all take care of the mothers and babies first and get some money to do this. I can see no harm in the Shepard-Towner bill, but only great good to come to Georgia from it.

The President: The motion is that this matter be referred back to the Committee, with Dr. Clark added to the Committee, for action on Thursday morning. All in favor say aye.

Motion carried.

*Committee on Arrangements:* Dr. E. C. Thrash, Chairman, gave the following report:

The program is the plan of our scientific work and the social functions are enumerated there. The chief function of this meeting will be the dinner on Thursday evening at 7 o'clock at which the members of the State Association are expected to be present as guests of the Fulton County Medical Society. The ladies have planned on the part of the Auxiliary of the State Association and the Auxiliary of the Fulton County Medical Society a dinner to take place at the same time in a different room. The dinner is due to be over at 9 o'clock and then we will have a dance in the ballroom. Those of you who are inclined to play golf will be welcome at any of the golf clubs and your badge will let you in. We have several excellent courses.

The Committee wishes to state to the House of Delegates that every member of the State Association is heartily welcome. Our arms are open to you and if you want and information in reference to the Association or in reference to Atlanta or in reference to having a good time, see any member of the Committee or see me and I will put you right.

The President: Unless I hear some objection this report will be accepted as given.

## REPORT OF THE COMMITTEE ON MEDICAL DEFENSE

To the House of Delegates:

The Committee on Medical Defense met at the office of the Association on April 22, 1925 to review the work of the year and prepare its report for your consideration. All members of the committee were present. Mr. Grover Middlebrooks, of the firm of Bryan & Middlebrooks, attorneys for the Association, was also present and gave a full report on all cases handled during the year.

During the year nine suits for alleged malpractice demanding a total of more than \$150,000 have been finally defeated. Six of these were tried before juries—all resulting in judgments for the defendants. One case was tried twice in the City Court and once in the Court of Appeals, requiring five days.

There are twelve suits and a number of threatened suits pending at the present time.

Our attorneys suggested that the retainer we pay them should be increased from \$1,000 to \$1,500 per year. After a full discussion the Committee decided to ask them to accept \$1,250 for the current year.

The total expenses incurred by your committee for the year are slightly under \$3,000 (actually \$2,798.51). All this money has been spent in the actual defense of suits for alleged malpractice against our members. No member of the committee has received anything for expenses of any kind. We have never had any special stationery printed.

In view of the number of pending and threatened suits the committee instructed me to ask for an appropriation of \$3,500 for next year.

The committee also requested the chairman to appear before the general session of the association on Thursday morning, May 14th, to explain the Medical Defense Feature to the membership.

Respectfully submitted,

M. A. CLARK, M.D.,  
Chairman, Committee on  
Medical Defense.

Atlanta, Ga., May 12, 1925

Dr. Clark: It was suggested last year that your Committee investigate the matter of getting a Liability Company to take care of things for us. The minimum amount for this would be about \$20.00 per capita. From the service we are getting now I think it would be wise to keep this up. Last year we had twenty-two cases, this year fifteen, and so far we have won all of them. Let me urge you again to be careful in your discussion with members throughout the State about expressing your opinion of any case that was

treated or operated upon about which you know nothing. The wise reply is "I do not know."

The President: That portion of the report relating to funds will go to the Council. What is your wish in regard to the rest of the report?

Dr. Wagnon: I move its adoption.

Motion seconded and carried.

*Committee on Hospitals:* As the Chairman of this Committee had died during the year, Dr. C. Thompson, Secretary of the Committee, presented the following report:

Dr. Thompson: This Committee met in Savannah during the meeting of the First District Medical Society. All the members were present except Dr. Harvard. They appointed me Secretary and instructed me to go ahead and find out what the situation was and let them know when I had this information. I immediately set to work and wrote the American Medical Association, the American College of Surgeons, all the National Nursing Associations, and every individual in every State who was making or had made such investigations that I could get in touch with, asking what had been done, what was being done, and how it was being done. As a result of the information I received I decided that since the problem affected the public, the doctors and the nurses, that it would be fair to investigate the subject through the laity, through the nurses and through the doctors themselves. To that end I wrote to the president of every federated woman's club in the State of Georgia. I wrote to the president of every County Medical Society in the State. I wrote to every member of the College of Surgeons in the State, and would have written to every registered nurse in the State but could not secure a list of them. I wrote many hundreds of letters, enclosing a self-addressed, stamped envelope, and assuring them the information would be held confidential without permission to disclose it. The Committee held another meeting last Sunday in Atlanta and reviewed a small part of the material I had collected. As the result of that consideration the Committee has the honor to make the following report:

Your Committee on Hospitals to which was referred the investigation of the nursing situation in the State submits the following report:

1. We have made a careful investigation of the nursing situation in the State of Georgia and find that there is a real trained nursing problem confronting us.

2. There is a shortage of nurses available for services, particularly in the rural districts.



3. We suggest that this Committee be continued and that it seek the co-operation of the hospital training schools for nurses, the State Board of Examiners for Nurses, and the State Nurses Association, in an effort to help relieve this situation.

J. O. ELROD, Pres.

A. H. BUNCE, Sec.-Treas.

R. M. HARBIN.

C. THOMPSON, Chairman.

Although Dr. Elrod requested the State Board and the Nurses Association to appoint a committee to assist us in this work we have heard nothing from them. Last week I received a letter from Dr. Selman stating that such a committee had been appointed, but we had not heard of it. We have found that whatever the situation is the doctors are directly responsible for it, since they control the hospitals and the training schools. Our suggestion does not mean that the same personnel should necessarily be continued on the Committee.

Upon motion duly seconded and carried the report was adopted as read.

*Committee on Necrology:* Dr. R. L. Miller, chairman, presented the following report:

As Chairman of your Committee on Necrology for the past two years, and realizing the great difficulty with which this Committee is yearly confronted in an endeavor to get a complete and accurate list of those members who have died, I wish to suggest that some amendment be made to the present By-Laws either of this Association or those of the component societies whereby it will be the duty of the several secretaries to report the death of any member of his Society to the Secretary-Treasurer of the Association. In this way and in this way only will there be any possible chance for us to have an accurate report each year.

Your Committee on Necrology begs to report that they have used every means possible to obtain a complete list of every member of the Association who has died since our last report. A letter was addressed to every local secretary in the State by our efficient Secretary-Treasurer asking them to mail the Chairman of this Committee a list of those members of their respective societies who had died during the past year. To this letter only five replied. One Councillor voluntarily reported for his District. The Chairman of the Committee later wrote to each Councillor asking for a list, and all save two replied. We wish to thank the Secretary-Treasurer of the Association for his aid in this matter and also the several Councillors.

While we do not say that we have a complete list of those who have gone on before us, we submit the following:

Dr. J. B. Baird, Dr. G. W. Battle, Dr. C. F. Benson, Dr. J. R. Brooks, Dr. W. G. Crumbley, Dr. T. L. Grooms, Dr. H. A. Herman, Dr. Max Jackson, Dr. W. J. Jennings, Dr. H. H. McGee, Dr. M. F. T. Myers, Dr. W. P. Rushing, Dr. J. B. Robins, Dr. W. B. Sharp, Dr. L. P. Stephens, Dr. J. H. Trotter, Dr. W. F. Peacock, Dr. Frank Mims.

Respectfully submitted,

R. L. MILLER, Chairman,

R. F. WHEAT,

GEORGE B. SMITH.

Upon motion of Dr. Selman, seconded and carried, the report was adopted as read.

### REPORT OF THE COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

May 13, 1925.

To the House of Delegates of the

Medical Association of Georgia:

Your committee begs to submit the following: At the last meeting in Augusta, a comprehensive plan of the contemplated year's activities of this committee was presented to and adopted by your body.

1. We did not circularize nor visit any district or county societies for the purpose of encouraging public health work. To meet the demands of the times the committee must have sufficient funds to conduct a systematic campaign, consisting of intensive follow-up work by circulars and personal visits.

Another retrenchment that we must record with regret is the discontinuation of the meetings of the State Health Council. When the State Board of Health had to withdraw its financial support in the form of secretarial help, the life string was cut abruptly. The committee feels that this co-operative health work is too important, both for the physicians and for the laymen to be dropped and suggests that this work be resumed and be financed and directed by the medical association.

2. In order to give greater impetus to the work of better health to public school children a joint committee from the Georgia Education Association and your committee met in Atlanta on December 27th. Those present were Superintendent R. B. Daniel, Columbus; Superintendent H. I. Knox, Jackson; Kyle T. Alfriend, Secretary of the Georgia Education Association; Dr. T. F. Abercrombie, Secretary of the State Board of Health; Dr. J. O. Elrod, President of the Medical Association of Georgia; Dr. A. H. Bunce, Secretary of the Medical Association of Georgia; Dr. James Thrash, Columbus; Dr. H. B. Neagle, Augusta and Dr. Theodore Toepel, Atlanta. It was agreed that the meeting should be made an annual gathering



of representatives from the two bodies in order to make the work permanent.

As a result of this meeting, the president of the Georgia Education Association, Superintendent Willis A. Sutton addressed the County School Superintendents on the subject of "Better Health, the Foundation of Better Citizenship," and the State Board of Health had an exhibit, showing preventive work in all its phases. The convention authorized a committee of three, appointed for three years to work with your committee; they also recommended the creation of a new office, that of supervisor of health and physical education, to be connected with the State Department. The convention also passed the following resolution which is of special interest to our association:

"Be it resolved, That the membership assembled endorses annual physical examinations.

"That for the protection of ourselves and of the children with whom we come in daily contact every public school teacher should have a physical examination before he or she is licensed to teach in the State of Georgia and that periodical annual physical examinations should be thereafter made.

"That arrangements be made with the Medical Association of Georgia to have these examinations gratuitously given."

In recognition of the foregoing your committee recommends that each county medical society co-operate with the school superintendents in giving this physical examination as requested by the Georgia Education Association. That the Health Committee from the Georgia Education Association with your committee and the secretary from the State Board of Health devise a uniform health examination blank, which is to be used by all examiners. Furthermore that the secretary of our association send an official communication to the Georgia Education Association, expressing our gratification in noting of the time allotted to discussions of health problems at their last meeting in Macon and giving assurance of our hearty co-operation.

3. Your committee recommends that this body endorses the publication "Hygeia," and urges that each county society make special efforts, or through its Women's Auxiliary, to give it wide circulation in the libraries, schools, and homes of their respective communities.

4. Your committee has not been able to encourage and make more popular, on account of no available funds, the scheme of "Periodic Health Examinations of the Ap-

parently Healthy." We have had a great deal of correspondence in regard to this matter with the Committee of Health and Public Instruction of the A. M. A., and are impressed now as we were impressed last year with the importance of making this examination popular with the members of our association and the laymen. We recommend that this body instruct the new scientific committee to secure a physician of national reputation to present this subject at one of our scientific sessions at the next meeting, the same as has been done at the meeting of the American Medical Association.

(To be continued in September issue)

### WANTED—DOCTOR

WANTED—Doctor wanted for small town.

Little competition. Best rural section in State. I have nothing to sell. If interested, write "H. E. C." care of The Journal.

### SITUATIONS WANTED

WANTED: Salaried Appointments for Class A physicians in all branches of the Medical Profession. Let us put you in touch with the best man for your opening. Our nation-wide connections enable us to give superior service. Aznoe's National Physicians', Member The Chicago Association of Commerce.

#### THE LINDORME TRUSS

The success of the Lindorme Spring Wire Truss is due to the detailed accuracy with which each is made and fitted to the individual case.

No stock Trusses kept on hand. Correspondence with Physicians invited.

A. H. LINDORME, M. D.

Suite 216

Physicians Bldg.

41 Forrest Ave., Atlanta, Ga.

Phone Connections.

# AWTRY & LOWNDES COMPANY

17 W. Cain St., Atlanta, Ga.

## PROMPT AMBULANCE SERVICE

Phone - Ivy 5613 & 5614

# STOVAR SOL

(REG. U. S. PATENT OFFICE)

Acetylamino-oxyphenylarsonic Acid

## Indicated in Amebic Dysentery

*Accepted by Council of Pharmacy and Chemistry A. M. A.*

Distributed in bottles of 25 tablets, each tablet 0.25 grams

May be obtained through your druggist

---

*Literature furnished on request*

---

MANUFACTURED BY

**POWERS-WEIGHTMAN-ROSENGARTEN CO.**

New York

PHILADELPHIA

St. Louis

# THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL PROFESSION OF GEORGIA

PUBLISHED MONTHLY under direction of the Council

Volume XIV

Atlanta, Ga., September, 1925

No. 9

## Original Articles

### PRESIDENT'S ADDRESS\*

A. W. Simpson, M.D.,  
Washington, Ga.

Gentlemen of the Eighth District Medical Association:

I shall not attempt to present to this body a scientific paper tho I believe such a paper might be in order.

Our efficient Secretary has arranged for you a splendid scientific program which in itself is sufficient.

I shall not burden you with a lengthy paper of any kind, but simply wish to briefly present to you some facts concerning our association, which I trust will be helpful and stimulating to us all.

After conference with the other officers of the association, for the year's work we decided that to make an effort to stimulate greater interest in County Societies and District Associations would be the most profitable course to pursue. We therefore decided to write one or more doctors in every county in the District, urging the organization or re-organization of County Medical Societies, and requesting that every member of the County Societies become a member of the District and State Associations. In this letter we appointed one doctor in each county on a membership committee, whose duty is both local and general, to look after the organization of County Societies and to keep up the interest of the doctors in County, District and State organizations. In other words, each member of this committee is a special representative of the District Association, whose goal is 100% organization in both County and District.

There were thirteen of these letters written, to which seven favorable replies were received.

The following physicians were appointed on this special committee:

Clark County—L. Gerdine.

Elbert County—A. S. Johnson.

Green County—Goodwin Gheesling.

Franklin County—Stewart Brown.

Hart County—W. E. McCurry.

Madison County—W. D. Gholston.

Morgan County—D. M. Carter.

Newton County—W. D. Travis.

Oeonee County—W. H. Hodges.

Putnam County—S. A. Clark.

Oglethorpe County—W. H. Reynolds.

Walton County—W. K. Swan.

Wilkes County—O. S. Wood.

Regarding County Societies, Ex-President J. O. Elrod in his address to the State Association said:

"I wish to insist upon the County Secretaries trying to keep a live County Organization. Try to have at least two public meetings a year, of your County Society, with a good full Public Health program. If possible, have some prominent layman and some visiting physician on your program. By having these public health meetings and presenting Public Health programs you will gain the confidence of the populace of your County and they will realize that your Society is not a working body for your own interest but for the good of humanity. These public meetings will benefit each individual member of your Society, so in this way the public will find out who composes your Society and the physician who is not a member of his County Society is soon ignored by the public. This will help you to

\*Read before the 8th District Medical Society at Athens, August 12, 1925.



make and keep your County a one hundred per cent membership county. Your Councillor will appreciate your efforts to make your county a one hundred per cent membership county, and will always be glad to render you any assistance that he can to keep your Society a live and working body."

Regarding District Associations Dr. Elrod said:

"Your District Society is a wonderful benefit to the physicians in your District, as a great many of them can attend this meeting who cannot attend the State Association. If you will keep your District Society programs up to the same high standard that you have for the past year, your attendance will be larger each year.

"To those of you who are, or may be, Secretaries of District Societies, I wish to say that you should demand of every physician registering at your meetings, his State membership card, before he is allowed to register and enjoy the privileges of your Society. I say this for the reason that I have seen a number of times during the past year, physicians attending District Societies, paying their District dues and enjoying every privilege of the Society, who were not members of their County Society nor could they be induced to join. Let me insist that both the County and District Secretaries help your Councillor all you can to keep your organization as near perfect as possible."

The following facts as given me by our Secretary, under date of July 1st, 1925, will no doubt convince every one of you that there was and is yet a great work of Medical organization needed in the Eighth District:

"Members of Eighth District Association: 1921, 41; 1922, 40; 1923, 40; 1924, 31; 1925, 65.

"Total No. physicians in District—215.

Counties having District members:

Clark: (1925)—25 members.

Elbert: Totally inactive for eight years.

Green: 1921, 2 members; 1923, 2 members.

Franklin: 1922, 1 member; 1923, 2 members.

Hart: Ten members, 100% per cent for the past eight years.

Madison: 1921, 1 member; 1922, 3 members; 1923, 3 members; 1924-25, none.

Newton: 1921, 3; 1923, 1.

Morgan: 1923, 5; 1924, 1; 1925, 7.

Oconee: 1923, 3.

Oglethorpe: 1923, 2; 1924, 3; 1925, 3; (Affiliated with Clark county).

Putnam: 1922, 3; 1923, 1.

Walton, 1925, 10.

Wilkes: 1921, 3; 1923, 7; 1925, 10.

"Note that the counties composing the active portion of the Association are: Clark, Hart, Morgan, Walton and Wilkes counties.

"The increase over previous years is very gratifying, but you will note that the membership is still less than one-third of the physicians in the District. Anything less than half seems to me a rather bad showing."

When you elected me your President, you conferred upon me a great honor, which I deeply appreciated, but at the same time I felt the great responsibility connected with this office.

Something has been accomplished during the past year, for which I am grateful; but which, without the splendid co-operation of Dr. Fullilove, Ex-Councillor, and Dr. Carter, Secretary, could not have been done.

I feel that we have started a good work, along right lines, and trust that my successor may see his way clear to carry on, and in so doing may have the hearty co-operation and support of this entire Association.

Finally gentlemen, I leave with you the wonderful thought as expressed by Dr. Marcus Feingold of New Orleans, when he said:

"People in all walks of life and all kinds of occupations gather periodically for the purpose of discussing problems common to the members of these groups, to gain experience and knowledge from the experience of others and thus to improve the affairs of each participant. In a profession such as ours, whose principal and primary object is to help and benefit our fellow men, this gain in knowledge is almost incumbent on us, because it is so essential for the good of those entrusted to our care. He who attends meetings regularly, even if he does not impart his experience to others, must leave a better man, better by the knowledge he has absorbed while listening to others. How much more valuable to the community is he

who imparts his knowledge and thoughts at the meeting in a discussion or in a paper. He gives to others his thoughts and his knowledge, but he becomes richer himself because of the intensity of thinking and because of the preparations that are necessary prerequisites of a paper or even of remarks in discussion.

"Presence at a meeting, hearing discussions and papers not only is of value to the beginner, but has been considered of importance to our masters. Naturally, not all that is transacted in every meeting is of the kind that signifies progress and betterment; some things presented may be of the kind that should be avoided and deprecated. But there is good also in listening to this kind because it teaches how to avoid mistakes of others. But, somebody would say, I can read all that transpires at a meeting in the transactions. This is true, and having the printed transactions has the advantage that they can be consulted and studied with absolute surety at any moment desired. True as all this is, nobody can deny that most of us are more deeply impressed by seeing or hearing a thing presented by the author than by the mere reading it; the impression is more vivid and lasting, and the time spent in listening at a meeting is thus more profitably spent than it would be by reading the same subject matter.

"Presence at meetings produces, I am sure, in different members of the audience, as it has in me, various emotions. These emotions must apparently fall into one or more of the following subdivisions: admiration for the subject or the speaker; feeling of one's own inferiority in having done so little; the desire to imitate that piece of work and that method; the determination not to overlook this or that in the future, and regrets at having failed to observe this and that.

"Wishes, regrets, determinations like these are bound to have only the most beneficial effects on our future activities, because they are stimulating to better performance of duty.

"When we stay at home and work in our own circle only, good work might be done and creditable, but our accomplishments, our

thoughts, our ideals, are slow to reach the outside world. The good we may have done has had only little influence, and, for the same reason, recognition by our fellow workers is sure to come only very slowly. At meetings, when we allow others to peep into our minds, a quicker estimate and appreciation of our value is gained, the influence for good spreads more quickly and is wider. Our leaders, the men who have honored and exalted our profession, all of them were regular in their attendance at meetings, spreading the knowledge they possessed and learning from the humblest and youngest in the meeting.

"Attendance at meetings has often led to ties of the most fruitful and warmest friendships among medical men the world over.

"Attendance at meetings must not be limited to those of our immediate circles. The larger the group of individuals banded together, the greater is the probability of valuable and stimulating contributions at that meeting."

### MYXEDEMA\*

Henry R. Slack, M.D.,  
LaGrange, Ga.

Primary myxedema in an advanced stage is not only a rare disease but, owing to the more wide-spread knowledge of endocrinology among the profession at large, is becoming less and less frequent. Hypothyroidism is now being recognized so early that proper organotherapy usually forestalls advanced myxedema. But even yet, as Anders recently pointed out, a certain number of cases are still being missed by physicians.

That is the reason for presenting this paper. Osler reports seeing only ten cases during his stay of sixteen years in Baltimore, and seven of these were at the Hopkins Hospital. The writer has seen only two cases in over thirty years practice. The last case was in November, 1924.

The following questionnaire was then mailed to the professors of medicine and leading consultants in Georgia, South Carolina and Alabama:

\*Read before the Medical Association of Georgia, May 13, 1925.

### Myxedema

1. How many cases have you seen?
2. Age? 3. Sex? 4. Color?
5. How long had they been affected?
6. What symptoms gave them the most trouble?
7. Were any of these post-operative?
8. How many?
9. Treatment and results obtained.
10. Remarks:

Replies were received from exactly 50% of these. Three reported never having seen a case of myxedema in private practice, and only one had seen four, so you see it is a rare disease. Atlanta report not included.

The diagnosis of myxedema is probably more frequently overlooked than that of any other disease. Many excellent physicians frequently diagnose myxedema as primary or secondary anemia, nephritis, eczema with cardiac degeneration, and so forth. Women are much more frequently affected than men—the ratio being six to one.

The symptoms are marked increase in general bulk of the body, a firm, inelastic, swelling of the skin that does not pit on pressure, which tend with the swelling to obliterate in the face lines of expression. The hair is thin and dry. The physiognomy is altered in a remarkable way: the features are coarse and broad, the lips are thick, the nostrils broad and flat, the mouth is enlarged and reminds one of a catfish. In other words, adult cretinism.

There is striking sluggishness of thought and movement. The memory becomes defective and headache is frequent. The temperature was subnormal and albumin was present in urine in both of my cases. Even careful diagnosticians fail to recognize the conditions unless they are on the alert. The advent of the basal metabolic unit has, Jackson says, practically obviated this difficulty, since it serves as an accurate index to the presence or absence of hypothyroidism. The isolation of thyroxin by Kendall, and the development of means for determining the basal metabolic rate have revolutionized the diagnosis and treatment of myxedema.

By measurement of the basal metabolic rate it is possible not only to confirm the diagnosis in evident or doubtful cases, but to determine accurately the progress of the

disease. The limits for a normal basal metabolic rate are 10 to —10 per cent.

Mild hypothyroidism exists when the basal metabolic rate is between —10 and —15 per cent. When the rate ranges from —15 to —40 per cent, myxedema is present in increasing severity as the rate drops. Jackson adds that the remarkable metamorphosis of a myxedematous patient following the administration of thyroxin, is to his mind “the most deeply dramatic event in modern medicine, affecting as it does, both the mental and physical make-up of the patient.” He says that thyroxin is far superior to desiccated thyroid because its strength is known and it is many times more powerful.

Case 2. Mrs. P. J. Age 65. Ala. 5 children, 1 miscarriage.

P. H. has had usual diseases of childhood. Typhoid fever and pneumonia. Menstruated at fourteen; passed climacteric at fifty. General health fairly good until six years ago, when she noticed that she had ceased to perspire from waist up. Had trouble with her eyes, and headaches, and stayed chilly all the time.

Examination: Short, obese, expressionless woman; lids puffed, especially inferior, but would not pit; lips thick, nose flat; skin dry, harsh and scaly, especially on hands which were swollen and spade-like. Hair thin and dry; almost no eyebrows.

Movements slow and languid. P. 100. Tem. 97 1/5. S. B. P. 130. Urine 1.012, acid and trace albumin.

Typical case of myxedema, except rather rapid pulse. Referred to me for frontal sinus operation as headache persisted after treatment by family physician, a local specialist, and operation in nose by specialist in Atlanta.

She was given protonuclein tablets, mixed glands, thyroid, thymus, etc., prepared by Reed and Carnick, eight a day. Her improvement was marked. She lost about two pounds a week, skin softened, swelling in face disappeared, lips thinned, expression became natural, movements much quicker, pulse 72, temperature 98-2/5. She looked and felt well except occasional headache, after twelve weeks treatment with protonuclein.



**Conclusions:**

- 1st. Myxedema is a very rare disease, but it does occur, and some cases are being missed.
- 2nd. It is becoming rarer every year due to organotherapy.
- 3rd. The beneficial result, physical and mental, from use of thyroid extract, thyroxin or protonuclein, is the most dramatic thing in modern medicine.

### DISCUSSION ON PAPER OF DR. HENRY R. SLACK

DR. ARCH ELKIN, Atlanta, Ga.: The subject of myxedema, or any condition in which there is a deficient secretion of the thyroid, is becoming more and more interesting. We are now beginning to study thyroidism in the under-secreting stage and to classify it just as the hyperthyroids have been classified. Fifteen years ago when I was a student we did not know anything about the under-secretion of the thyroid gland, except to call people cretins. Due to the work of many men throughout the country there are now definite classifications for the under-secretion just as for the over-secretion. Dr. Slack is correct in saying that myxedema is rare. We have had an opportunity in the Good Samaritan Clinic to observe many cases of thyroid disease but have seen only three that we thought were myxedema.

It is rather difficult to draw a sharp line of demarcation between the thyroid in the state of over-secretion, and the myxedema case or a cretin. They all give practically the same symptoms, there simply being a variation in the degree of the secretion and how it affects the patient. All of the patients improve with the administration of thyroid.

It is remarkable how much thyroid some people can take. Of course, we all know that the thyroid is the rattle snake, so to speak, of the ductless glands. We can always get physiological effects from thyroid. We have been able to give a girl of fourteen as much as forty-eight grains of thyroid in a day and under this dose the young girl was apparently brought back to a normal state of health.

Dr. Slack's paper is very timely and calls our attention to the fact that we should look for hypothyroid. Do not, because you have a fat and probably a dull individual, assume that you have someone in whom you ought to put your finger on a tumor and try to classify that individual as a thyroid. You can give 1/10 grain of thyroid in tablets and increase this by 1/10 grain a day up to the

point of tolerance. The tolerance is manifested by the increased sweating and so on. If you have an individual who can take seven or eight grains a day you have a high tolerance and therefore probably have an individual who is suffering from under-secretion of the thyroid.

I think the paper was very timely and thank Dr. Slack for bringing it to our attention.

DR. HENRY R. SLACK, LaGrange, Ga.; (colsing): The reason I have presented this paper is because I have been a member of the Medical Association of Georgia for thirty years, and have attended twenty-five meetings in that time, and have never seen a paper on myxedema on the program. As organotherapy is under discussion a great deal at this time, and as the last patient was referred to me for a sinus operation—she had been to Atlanta, and had been treated by a specialist in Opelika and by three family physicians, I thought it might be well to bring this before you. I read much the same paper before our County Medical Society and one of the doctors there said he was so glad I presented it because he had the same sort of case and did not know what it was.

Someone wanted to know why I used protonuclein instead of the thyroid gland. Simply because our druggist did not have any fresh thyroid gland but had plenty of protonuclein and the patient improved so much that I saw no use in changing. I have used protonuclein in many cases with great benefit, particularly in cases of general deterioration. It certainly does restore old men better than anything I ever have tried.

### SOME EXPERIENCES WITH GAS INSUFFLATION OF FALLOPIAN TUBES

Of ninety-four patients on whom 115 carbon dioxid insufflations of the tubes (Rubin tests) were made by G. L. Moench, New York (Journal A. M. A., June 13, 1925), up to four on the same patient, the result was that twenty-nine women were found to have closed tubes and sixty-five open tubes. Of the ninety-four patients, eighty-eight underwent insufflation more than three months ago; of these eighty-eight, thirty-three had closed tubes and fifty-five open tubes, and of the latter, seven later became pregnant. Not a single instance of pregnancy occurred in those patients who, according to tests, had closed tubes. Moench concludes that the carbon dioxid insufflation of the fallopian tubes is a valuable and safe test when properly carried out. The therapeutic value of the Rubin test is small, but real beyond a doubt, as shown by the fact that the tubes, after several carbon dioxid insufflations, often become more patent than before.

## GASTRIC AND DUODENAL ULCERS WITH THE MEDICAL TREATMENT\*

J. D. Gray, M.D.,  
Augusta, Ga.

There are a few cases of gastric and duodenal ulcers that do not give definite symptoms until they either perforate, hemorrhage or obstruct. Most cases give a very characteristic history which is as follows: Pain in epigastrium described as an uncomfortable sensation, gnawing, dull ache or sharp pain coming on two to five hours after eating, relieved by food and soda. Quite often there is no pain before breakfast. The patient is often awakened at night but usually relieved by a glass of milk which they have learned to place by the bed before retiring. The pain usually increases in intensity until relieved by food or complete evacuation of the stomach. This is an acute or sub-acute case, the pain comes constantly and is present every day.

Some older cases give the following history: Pain sharp in character, not relieved by food and soda but frequently relieved by vomiting. Indeed food often increases the pain. If a careful history is taken it will be found that the pain began in young adult life and at that time was relieved by food and soda. Now the ulcer may be obstructing, perforating or may have undergone carcinomatous degeneration.

In the beginning there are definite attacks lasting from a few days to a few weeks. At this time the patients often place themselves on a diet of milk or limit themselves to soft food, take a dose of soda after each meal and are soon relieved for a time. They gradually let out on the diet and sooner or later another attack follows. These attacks may occur over a period of ten to fifteen years.

In taking a history for "Stomach Troubles" there are a few questions that are rather important.

1. How long have you been sick?
2. Have you daily discomfort or only attacks?
3. Does your discomfort last all day or does it only come at certain times?

Does it occur early in the morning?

4. Have you real pain in the stomach or only a sense of fullness?
5. If fullness, is it continuous or only after eating?
6. Do special articles of diet cause discomfort, and if so, what?
7. If you have pain what is it like and when does it appear?
8. Do you vomit? When? What?
9. What relieves the pain?
10. Bowel movements, Time? Pain? Consistency? Frequency? Blood or mucus?
11. General conditions—Eructation of gas? Palpitation? Appetite? Food? Weakness? Heartburn?

### Cause of Pain.

The cause of pain in gastric and duodenal ulcers is a subject that has been widely discussed. We know that the distress of ulcer (1) is absent when the stomach is entirely empty, (2) it appears an appreciable time after eating. (3) It is relieved by food, (4) it is relieved by alkalies. We know that in most cases there is too much acid both quantitative and qualitative. Many think that the acid is the cause of pain. We know though that alkalies relieve when there is either a normal, a hyperacidity or an acidity. Hurst believes that inhibition of pyloric relaxation, excessive peristalsis and hypertonus is the cause of pain. In nearly all cases we have some pylorospasm and hypertonus so it would seem that they are the most frequent causes for distress. It is probably not due to a mechanical irritant. The pain may be altered by malignant degeneration, perforation and perigastritis. Pain persistent or unrelieved, means no ulcer, perforation or malignancy.

Vomiting is not a common symptom even when the pain is at its height. Of course after there is an obstruction the patient vomits, but usually vomits a few hours to a few days after eating and not immediately after taking a meal.

Vomiting of visible blood occurs in less than ten per cent of cases but this is not an index as to the frequency of bleeding. A daily stool examination for occult blood on a meat free diet will be positive in a large number of cases. In ulcer it is likely to be

\*Read before the Medical Association of Georgia, May 13, 1925.

\*From the Savannah Valley Clinic, Augusta, Ga.



positive intermittently, but in cancer it will be found constantly positive. Sometimes there has been enough loss of blood to cause anaemia. William Mayo says that an acute unheralded hematemesis is usually due to some cause other than ulcer..

**DIAGNOSIS.** The diagnosis can most often be made by symptoms, x-ray and gastric analysis, though the symptoms are first in importance, the x-ray second and the gastric analysis last. I believe the best method for doing a test meal is as follows: In A. M. remove all of the stomach contents. Give two slices of bread and two glasses of water and remove the contents one hour later. It has been shown rather conclusively with the Rehfuß Fractional method, that if the specimens were withdrawn in rapid succession there would be as wide a variation in the acidity per cent as if you waited fifteen minutes between specimens. There is one condition I would like to call attention to in the differential diagnosis and that is mobile colon. Many cases of mobile colon give symptoms of duodenal ulcer but the differential points are these: In mobile colon the pain may or may not be relieved by food and alkalies, there is some relief in lying down, usually the pain is relieved by taking a cathartic and it does not occur before every meal, or every day.

**TREATMENT.** The principles of treatment consist mainly in (1) neutralizing the acid, (2) relaxing the spasm, (3) delaying the secretion of acid, (4) lessening the peristaltic waves in frequency and force, and (5) drainage.

As you all know there are two methods of treatment, medical and surgical. There are many surgeons who think all ulcers should be operated upon. Then there are many internists that think none of them should have an operation. I think a conservative view is to treat the patient from four to six weeks with the proper medical treatment, if not relieved in that time resort to surgery. This view is that of Dr. George Crile and I think a very good one. Monahan says: "It is at least arguable that the necessity for surgical relief in many cases is due to a too perfunctory trial of medical treatment." He advises that before surgical treatment is instituted a really serious attempt to treat all cases of chronic gastric ulcers by medical

treatment should be made. It is best to have no half measures."

We are more or less familiar with the various diets, most important of which are: Sippy, Lenhartz, Smithies, and later a diet by Coleman. There are of course several modifications of these diets. The one most commonly used is Sippy's. Sippy recommends three ounces of equal parts of cream and milk every hour from 7 A. M. to 7 P. M. Cereals (rice, oatmeal, farina), soft eggs, crackers and bread and butter are gradually added until at the end of the first week, three ounces of milk and cream every hour, two or three soft eggs and six to nine ounces of cereals are given daily. A powder consisting of equal parts of soda bicarbonate and heavy calcined magnesia is given every hour alternating with a powder containing carbonate of calcium 10 grains and carbonate of soda grains XXX. At the end of three to four weeks the patient is getting three small meals, cream and milk every hour, vegetable purees, potatoes, cooked fruits, all ordinary desserts, small amount of meat. After each meal the powder is given every half hour for two or three doses. While under this diet the stomach is kept in a constant state of activity for twelve hours out of the twenty-four.

#### **The Lenhartz Diet**

200 CC. of milk and two eggs are given on the first day. These are gradually increased until the end of the first week 900 CC. of milk and eight eggs are given daily. On the third day sugar is given and gradually increased to forty grams on the ninth day. Rice is allowed on the seventh day. Zwieback on the eighth, and butter on the tenth day. In this diet there is a relative excess of protein.

#### **Smithies Diet.**

For from three to seven days one-half ounce of warm water is given every hour while the patient is awake and occasionally during the day orange and grapefruit juice. During this time enemas consisting of one ounce of fifty percent alcohol, one ounce of glucose and 240 CC. of physiologic sodium chloride solution are given every hour by the drip method. Ten drops of tincture of opium is given with each enema for the first few days. Gruels made of rice, wheat, oatmeal, sago, cornmeal, etc., are given in



quantities of four to six ounces on the third to seventh day. The number of enemas is reduced when mouth feeding is begun and are discontinued on the fifth day thereafter. From the fourteenth to twenty-first day barley water, Zwieback, butter, milk and boiled milk, puddings, custards, purees, Salisbury steak and eggs are gradually added to the menu. One ounce of warm water, orange juice or grapefruit juice is allowed whenever desired throughout the treatment. The diet is continued from six to seven weeks.

#### The Coleman Diet.

For three to five days no food is given by mouth. If thirst is not controlled by enemas, one to three ounces of warm water may be allowed whenever desired. Cracked ice may be held in the mouth provided the water swallowed does not cause pulorospasm. Glucose enemas are begun on the first day. They consist of thirty grams of glucose in 300 CC. of physiologic sodium chloride solution. A soapsuds enema is given every morning. The glucose solution is given hot by the drip method at a rate that consumes from one-half to three-fourths of an hour. Three to four such enemas are given daily and are continued throughout the treatment.

On the fourth to sixth day feeding by mouth is begun. The only foods permitted are white of egg and olive oil or butter fat. The interval of feeding should not be less than two hours. The quantity of food should be increased as rapidly as the stomach can take care of it. From one to one and one-half ounces of olive oil and the whites of three to four eggs may be given the first day. These are gradually increased to a maximum of 150 CC. of olive oil and six to eight whites of eggs daily. It may be desirable to use some other fat and in such instances unsalted butter may be used. Occasionally the patient rebels on both fats and cream may be used. Twenty-three ounces of cream is required to replace five ounces of olive oil. The diet should be continued for three to four weeks and then only specially selected food given for several months.

On such a diet the stomach is given absolute rest for three to five days. The foods given by mouth inhibit gastric secretion, reduce gastric motility to a minimum and the

surface of the ulcer is protected by a coating of fat.

With these diets it would seem best that the patient should be in bed and in a hospital or have very close attention at home. Many of the patients that we get have a chronic ulcer and are unable to stay in the hospital or in bed. I don't believe the majority of patients will carefully follow Sippy's and these other diets if allowed to be up. The following is a treatment for the ambulatory patient with which we have had very good results:

- (1). From one-half to one teaspoonful of Carlsbad salts is given in a glass of warm water before breakfast.
- (2). One-half teaspoonful of alkaline powder is given after each meal and whenever there is pain. The alkaline powder consists of equal parts of bicarbonate of soda and magnesium oxide.
- (3). Tincture of belladonna, ten drops before meals, increasing the dose to point of tolerance, is given.
- (4). Olive oil, one tablespoonful before dinner and supper.
- (5). Bismuth Subnitrate, a rounding teaspoonful before going to bed.

#### Diet.

Eat five times a day, taking some milk with the addition of cream with buttered crackers between meals.

Toasted bread, cold light bread, cereals with cream and sugar, beaten biscuits, cream soup, rice, hominy, butter, eggs—soft boiled or poached, cream potatoes, sponge cake tapioca and rice puddings are allowed.

Avoids fruits, salads, green vegetables, all fried food, gravy, meat soup and meat.

After six to eight weeks of this diet the following instructions are given: Avoid tea, coffee, alcohol, hot bread, cake, pancakes, puddings, pies, pastry, baked beans, pork, corned beef, raw vegetables, raw fruit, nuts, candy, and all fried food.

May eat: Broiled or stewed beef, mutton, breast of chicken, fish, cooked vegetables, cooked cereals, cooked fruits, rice milk, cream soups, and vegetable soup, soft boiled or poached eggs.

These instructions are to be carried out from six months to one year and maybe indefinitely.

## DISCUSSION ON PAPER OF DR.

J. D. GRAY.

DR. GEORGE M. NILES, Atlanta, Ga.: I wish to commend Dr. Gray's precise presentation of the treatment of gastric and duodenal ulcer as it is generally looked upon by the internist. Surgeons look at it from a different point of view. The long continued hospital treatment is out of reach of most patients, and it requires much moral stamina on the part of the patient to stick to it. Dr. Gray's modifications are all right and in nearly every instance will bring success. Those cases of extreme ulcer, of gastric ulcer, in women are easier to handle that way for the women are more faithful. They will stick to the treatment even after they feel pretty good, but the men, particularly the business men, after they feel pretty good they will become derelict about the treatment until they have severe trouble and come back.

I believe we have to suit the treatment to the general condition of the patient and the moral stamina of the patient in each case. Dr. Gray covered the subject in a definite, concise manner, and I wish to commend him for his effort.

DR. W. R. DANCY, Savannah, Ga.: The Doctor spoke of "silent" ulcers, especially in regard to symptoms of pain and other symptoms usually present in ulcer. I have had two such cases, both with marked hemorrhage. These patients bled to such an extent that any interference from the operative standpoint would have been absolutely impossible. Both of these patients vomited blood and passed blood copiously from the bowel. One of them had had no previous symptoms that were at all suggestive of ulcer. The other one, six years before, had had some symptoms that were very suggestive of ulcer. Both of the patients are on the road to recovery, both are up and ready to go back to work.

There is quite a difference in the appearance of people when you find them at home and when you find them dressed up for the ball. I had the pleasure of visiting Dr. Sippy, the Mayo Clinic and Dr. Smithies. I visited Dr. Sippy and he showed me many ulcer cases. His treatment was just as simple as Dr. Gray and Dr. Niles and I carry out. He told me that in the acute ulcers he kept them on cream and milk for ten days and if they were very acute they got nothing but milk for five weeks. He insisted on the patient remaining in bed, and he insisted on alkalies to the extent that once or twice a day he would have the stomach tube put in and the contents re-

moved to see if the contents were neutralized. If not, he would give more alkalies. As to all the fancy treatment and diet we find in the text books in regard to the Sippy plan, doubtless he did this in some cases but he was not doing it in Chicago when I visited him two years ago.

Dr. Smithies does not believe in loading the patient up much with alkalies. He believes in keeping the patient on his feet, allow him to do light work and enjoy his usual pleasures and take a little more liberal diet.

As to the Mayo Clinic, you will find all the surgical men in the Mayo Clinic believe all the cases of ulcer should be operated on and operated on right now. Dr. McCarty, who is one of the pathologists at the Mayo Clinic, has quite a different view of the subject. In speaking of the acute ulcers he has made this statement: "If I had an acute ulcer of the stomach or duodenum I would hunt up the best medical man I could find and take his treatment. If I was not relieved within eight or ten weeks I would hunt up a surgeon. If I was not relieved then I would hunt up a medical man again. I would do this about three times. If I still had recurrent ulcer I would be operated on. If I had a chronic ulcer I would, of course, be operated on because the incidence of cancer is much greater than in the acute ulcer." Therefore we have two very different views from the same clinic.

My criticism of the medical man is that he usually starts out on the right line but does not persist long enough to cure his cases. He would do just as well as the specialist if he would pay more attention to his medicine and his diet and his police duty to the patient.

DR. HAL M. DAVISON, Atlanta, Ga.: One cannot always tell from the gastric juice what the symptoms are going to be. In the last analysis the fluoroscope will give the diagnosis and the greatest indication for treatment in gastric diseases. We see large numbers of cases with enteroptosis that give the same symptomatology that acute ulcer gives. We see cases with gastropnoxis with a low stomach and low acidity with a high peristalsis. It is reasonable to think that in this type of case more atropin is indicated than in the cases that do not have the increased peristalsis and pylorospasm. Dr. Dorsey called my attention to the fact that the cases with hypochlorhydria will give the same symptoms and in those cases the powders will give the same relief, and are indicated just as in the cases with high acidity. These are points which we often miss unless a man like Dr. Dorsey with large



insight into medical cases, tells us about them. The treatment in these cases is about the same except that we have to have repeated fluoroscopic examinations to tell us what we are doing.

DR. L. HOLTZ, Atlanta, Ga.: I wish to say a word about the treatment of gastric and duodenal ulcer in the European clinics. I had an opportunity to spend almost two years in a hospital in Berlin and we had a large percentage of gastric and duodenal ulcers, especially after the war, due to the poor food. The Sippy treatment is almost entirely neglected there. They never give alkalies unless they know there is increased hydrochloric acid. In the Sippy treatment it is given as routine, whether there is increased acid or not. Unless he is very acutely ill the patient is not put to bed. He is allowed to attend to his work and attends the clinic only once in two or three weeks. He is given a general diet, is told to cut down the acids and fried foods, but is given a general diet. The experience there on a large series of cases has been just as good as with any particular diet.

DR. W. E. McCURRY, Hartwell, Ga.: One thing was not brought out in the paper and that is the value of the string test. If one puts down a string with a bulb on it, using the Einhorn or Rehfuess tip and even if the ulcer is not bleeding he will get a bloody string in the morning, and can form a good estimate of the location of the ulcer, almost as good as by the x-ray examination, by the location of the stain on the string.

DR. GEORGE C. MIZELL, Atlanta, Ga.: One would think this was a meeting of internists rather than a general meeting, but perhaps they feel that this subject is somewhat settled. If we read some of the recent papers that have been published we will find that it is quite a new subject and that nothing is settled, either as the cause, symptomatology or treatment. Dr. Gray rather minimized the importance of the stomach tube and said we could make the diagnosis from the x-ray. This is true in regard to the ulcers near the pylorus but is not true in regard to the ulcers in the fundus of the stomach. In many of the cases near the fundus of the stomach the only way in which one gets the diagnosis is by means of the stomach tube. We find blood in the stomach continuously. Many are opposed to the use of the tube because of the danger of producing fresh bleeding.

The fundus ulcers do not give many symptoms. I have seen several cases in which vomiting was the only symptom. There are many phases of this subject that

I would like to discuss but time does not permit.

In regard to the Rehfuess tube, I think in a few years you will find that it is of no use. It has been proven that the degree of acidity depends upon where the tube is in the stomach. If it is near the pylorus the acidity is high and if it is up high there is not much acid.

In regard to the Sippy treatment, in my experience more people cannot take the treatment than can take it. The Alkaline treatment had its beginning in Georgia. Dr. Johnson used identically the same treatment years before Sippy, and we all follow out the same treatment more or less in our medical treatment.

Several of the speakers have emphasized the fact that not many of these patients can go to bed and stay there, and we have to devise a method of treatment whereby they can be kept on their feet, and this can be done.

I think surgery for ulcer of the stomach should not be taken into account except where there are adhesions, or extensive induration at the pylorus which is producing obstruction.

Another point that has not been emphasized. I think, is that almost always, I am inclined to say—if I did not wish not to appear dogmatic I would say that gastric ulcer and duodenal ulcer are secondary propositions, secondary to focal infection somewhere in the teeth, tonsils, gall-bladder or appendix, or that they are mechanical processes in which there are adhesions. These things must be taken care of and then it is an easy matter to treat the ulcer medically, except where you have the stasis due to adhesions and constriction, which always calls for gastroenterostomy. Except for these cases I believe that ulcers will remain well when once cured with medical treatment.

DR. T. C. DAVISON, Atlanta, Ga.: I do not think the subject should be closed without a word from a surgeon. The medical treatment is all right so far as it goes, but many cases are not relieved by medical treatment and the various diets prescribed. I am sure the gastroenterologists and medical men will admit that this is true. I have noticed many cases at the Grady Hospital that have been treated for years by internists and finally turned over to the surgeon for operation. In many instances no ulcer was found but they were cases of chronic cholecystitis, and adhesions to the duodenum, with retention at the end of six hours. These cases should have operative procedure for the gall-bladder trouble. Many cases of so-called ulcer are gall-bladder trouble in the beginning and not ulcer at all.



DR. WILLIS B. JONES, Atlanta, Ga.: I did not know there were so few surgeons present. There seems to be only one here. I think that medical treatment of ulcer should be tried in every case. I do not like to operate on ulcer until the medical man has had a trial. The majority of ulcers I have had the pleasure of operating on have been old ones. I have seen very few acute ulcers.

There is one point that we must always bear in mind, that every healed ulcer base is a potential site for cancer. If you will analyze your cases of cancer of the stomach you will be surprised at the number that give a history of a long standing previous indigestion. The patients often have not consulted a doctor at all, but have treated themselves with soda and various other forms of medicine. I think every ulcer, after it has had a course of treatment in the hands of a qualified medical man, if the patient is not relieved, should have surgery. In the surgical treatment I think every ulcer should be excised, if possible. If they are in the stomach away from the pylorus a small excision is all that is necessary. If they are near the pylorus, with beginning pressure obstruction, where the operation we might do would increase the obstruction, I think a gastroenterostomy in addition to the resection of the ulcer should be done in these cases.

There is one point I wish to mention in reference to the differential diagnosis—if the essayist brought it out I did not hear it—and that is the symptoms we often get from the appendix are identical with those from ulcer. Not infrequently have I opened an abdomen expecting to operate on an ulcer and found the stomach and duodenum absolutely normal, but the appendix bound down by adhesions. In these cases removal of the appendix relieves the patient of all symptoms.

DR. A. J. MOONEY, Statesboro, Ga.: I wish to give you the views of Martinez on the pain in gastric ulcer. We know how frequently the patient, after the intake of food, will complain of discomfort and burning and suddenly he will have an eructation of gas from his mouth and immediately feels like taking nourishment. Martinez put a patient before the fluoroscope to see what took place. When the paroxysm of pain was on and while he was observing it he noted that when the pylorospasm relaxed the patient had relief of pain and was able to take nourishment. Therefore, he concluded that the pain was due to the pylorospasm, plus the hyperacidity. Statistics

tell us that only a small percentage of duodenal ulcers ever become cancers. Therefore, it is perfectly right for the patient to have the nine proverbial medical cures before he comes to operation, but let us remember that every gastric ulcer is a potential cancer when situated near the pylorus in the stomach. The "silent" ulcers, as Dr. Daney brought out, are a study in themselves. The patients present no distress, no symptoms, except one which stands out like a beacon light. The patient is seized with severe pain and board-like hardness and operation within a few hours will reveal a perforated ulcer. In those cases I think it is not necessary to do a gastroenterostomy. The repair of the perforation cures the ulcer and very rarely do these patients have to have a second operation.

Speaking of the operation on gastric ulcer, the pendulum of surgical science swings. A few years ago the tendency was to posterior no loop gastroenterostomies, but the statistics showed that we were not curing quite enough cases to warrant the procedure. Then the pendulum swung back to medical treatment. Operative statistics are not so encouraging except in the cases where there is scar tissues in the stomach which produces obstruction and makes us fear the possibility of cancer. I think I cured about 55 per cent of my gastric ulcers by posterior no loop gastroenterostomy. I relieved probably 25 per cent more. I feel that possibly it would be best to let the medical men work it out a little while longer and see what the surgical pendulum does within the next few years.

DR. G. N. COKER, Canton, Ga.: There is just one point I wish to bring out in regard to operating on gastric and duodenal ulcer. After you operate on these patients there must be the same careful regulation of dietary treatment as before the operation. If this is not done these patients are subject to recurrence of the ulcer, either at the point of operation or at other areas in the stomach or duodenum.

DR. J. D. GRAY, Augusta, Ga., (closing): Cancer of the duodenum following ulcer is very rare. I do not believe that many patients would carry out the Sippy diet very well if allowed to go home. I tried this in one case and the patient went home and he said he tried it for two weeks but that the Sippy diet was "no good" and never had brought any relief.

I believe in giving alkalies whether there is hyperacidity or not. The patients are relieved of the symptoms just the same. I knew the surgeons could not keep quiet on

this subject, but since the paper was on the medical treatment most of them held off. I am strong for the surgeon, where he is needed. I can hear that great surgeon, John Deaver, say "There is just one treatment for gastric and duodenal ulcers and that is the aseptic scalpel." I do not believe that, but it is wonderful what advances they have been making in operating on the stomach. In 1881 the mortality was 100 per cent, but since then it has definitely decreased. I do not know what the present mortality is but it is very much lower. I do not believe the surgeons get much good results from surgery alone, and one fact must be remembered; the surgeon treats his cases medically after he operates on them.

### X-RAY IN THE DIAGNOSIS OF DUODENAL ULCER\*

L. P. Holmes, M.D.,  
Augusta, Ga.

When it is taken into consideration that the occurrence of Duodenal Ulcer is approximately found in the proportion of four to one to Gastric Ulcer, the question of the diagnosis of this lesion becomes important.

Since about 95 per cent. of all duodenal ulcers occur in the first portion, commonly called the cap or bulb, and since the normal duodenal cap is a constant entity and can always be visualized on the X-Ray film, the diagnosis of duodenal ulcer by X-Ray method has become one of the simplest of all upper abdominal diseases.

It has only been about ten years ago that Cole first reported his work on the duodenal defect by serial radiography. This work stands out as the pioneer study in this particular field, and made possible the diagnosis of this malady, in a much larger number of cases than prior to his discovery.

Before taking up purely the X-Ray side of this question, it would be well to run over the clinical aspects which lead us to a more detailed study. When an intelligent patient recites his history to the physician the diagnosis is usually so clear that there is little room for doubt. But unfortunately all patients cannot give a satisfactory history, and again, many cases have duodenal ulcer

in which leading questions will fail to uncover any evidence of the disease.

The typical ulcer history of recurring attacks of disturbance of digestion, characterized by hunger pains coming on from two to four hours after meals, and relieved by swallowing food or alkalies, is only obtained, in about 50 per cent. of the cases, or possibly less.

In some of the cases with hyposensitive abdomens their first symptoms prior to examination will be sudden and often severe hemorrhage.

Others (about 30 to 40 per cent.) will give typical histories, but suggestive, in that they have had prolonged dyspepsia.

Conversely, we have had any number of cases who gave rather conclusive ulcer histories, who when examined showed no evidence of ulcer.

Physical examination of duodenal ulcer does not give us much information unless the ulcer is obstructing the outlet of the stomach, or is accompanied by malignant change. Epigastric tenderness and rigidity of the upper rectus muscle are found in a considerable proportion of these cases, but they are not at all peculiar to this disease.

The use of the stomach tube to test the secretion and emptying time of the stomach no doubt has to a certain extent been set back by the Roentgen Ray, but we should never minimize this important adjunct to ulcer diagnosis.

No less an authority than Moynihan once made the assertion that "Hyperacidity is ulcer," but this has long since been disproved as we now know that ulcer may be present with a sub-acid curve with all the figures below normal.

Crance has pointed out the two types of acid curves most typical of ulcer are the one which starts high and remains high (with the usual Rehfuess tube method) and the other which starting at normal or lower than normal constantly ascends, remaining at a high or near its high level when the stomach is empty.

The test for occult blood in one or more fractions of the Ewald test meal is found in a very small percentage of cases, and blood in the stool is probably less frequently

\*Read before the Richmond County Medical Society, January 16, 1925.



found. It is only of value when positive and in the stool it is not conclusive as it may have come from some point in the gastro intestinal tract below the stomach and duodenum.

During the period when acute and chronic bleeding, perforation and mechanical obstruction were the main points in diagnosis of ulcer, bleeding was one of the major points in the diagnosis. These symptoms have gradually lost their importance as more modern means of examination have been discovered, and the incidence of hemorrhage was reduced to about 20% in the cases diagnosed.

Ulcer occurs in all races and climates and the seasons of spring and fall seem to produce them in greater numbers..

As stated before, the proportion of duodenal to gastric ulcer is approximately four to one, as shown by the reports of the Mayo Clinic, from January 1st, 1906, to January 1st, 1920. Operations were performed on 1191 patients with gastric ulcer and 4532 patients with duodenal ulcer. A very small percentage of patients have ulcers in the stomach and duodenum together; only in 203 instances were they found combined, in the series mentioned above.

Our method of examination of gastric and duodenal cases is as follows:

The patient is instructed to simply omit breakfast on the morning of the examination. No cathartics are ordered twenty four hours prior to this time, as an exaggerated peristalsis might be seen on the fluoroscopic screen from the cathartic.

If a test meal and fractional or single extraction is to be done this is completed before the patient comes to the X-Ray room.

The patient, if strong enough, is first stood at the verticle fluoroscopic and given the usual water barium meal. This meal is purposely made rather heavy in order to get as dense a shadow as possible. The patient is instructed to drink the meal and it is watched carefully as it goes through the esophagus for any evidence of pathology there.

On entering the stomach there is usually a delay of several minutes before the pyloric sphincter opens for the duodenal cap to fill.

At this time the lesser and greater curvatures are examined for any evidence of filling defects, ulcer craters, tumors or incisurae, as well as for position, size, motility and mobility. The value of the screen cannot be over estimated here because we have the opportunity to study the organ in motion under the palpating hand, as well as change of position of the patient in order to bring parts being studied into proper relation with the fluoroscopic screen.

When the first portion of the duodenum fills it is usually roughly triangular, not unlike the priest's cap from whence the name "cap" was derived. Its contour is quite smooth and different from the irregular shadow thrown by the other portions of the intestine.

A normal cap should be visualized on the screen and plate and we may safely assume that if it cannot be radiographed it is abnormal.

The average case is simple, but occasionally pyloric spasm, pressure from adjacent viscera, and pathologic conditions as gall stones, diseased gall bladder and reflex spasm from a chronically inflamed appendix will be the cause of an imperfectly filled or deformed duodenal bulb.

Occasionally we find the actual crater on the border of the duodenum and we can estimate for the surgeon whether it is penetrating or perforating. Frequently on the opposite wall to the ulcer crater there is a definite indenture (called incisura) which originally was muscle spasm and may have finally become organized and permanent.

Usually if the crater or mucous erosion of the ulcer is not visualized the duodenal bulb is seen to be in a state of spasm and its usually smooth walls are very irregular and serrated and the cap then takes on the "pine tree" deformity suggested by Carmen.

The characteristic feature of the typical ulcer history is pain, occurring from two to four hours after meals. It has been shown that this pain is not caused by acidity, but by peristalsis.

Many researches have proven that pain and peristalsis are synchronous, and that acidity may be very low at the time of the worst pain. Hyperacidity, when present, may reflexly cause contraction which may



cause pain, it is not the direct or only causative factor.

When hyperperistalsis (so common in duodenal ulcer) is not caused by excess of acid, it is due to reflex effects of ulcer itself, and therefore should be expected to vary with the location of the ulcer as regards nerve paths, and with the extent of the inflammatory zone, and its hypersensitive nerve endings.

These variable factors could possibly explain the frequency with which typical histories are obtained.

The X-Ray evidence of cap deformity is based then, first, upon an actual break in the duodenal mucosa and which often times is so small that it cannot be seen, and, second, upon the incident reflex spasm deformity which accompanies the irritated nerve endings.

Quite small ulcers not infrequently cause massive and persistent deformity of the bulb, depending upon their location.

The healing of the irritable inflammatory zone around an ulcer may explain the lessened cap deformity in spite of the fact that the scar may be as large as the ulcer.

Occasionally, following a report of cap deformity, the surgeon fails to find duodenal ulcer at operation.

This is explained by the reflex spasm of marked degree with bulb deformity which may accompany very shallow ulcers (seen by the Roentgenologist) without induration of the base or scar formation, enough to be seen on the duodenum at operation as the general anaesthetic has abolished all these reflex spasms.

In passing it may be of interest to mention duodenal ulcer in infancy. The scarcity of literature on this subject is surprising, and if taken as a criterion, one would almost believe it does not occur in infancy. However, it will probably become less rare as we look for it.

Emmet Holt, in December, 1913, collected 91 cases in the literature and added four of his own, seventy-four of these cases were published after 1908.

Dudley W. Palmer charted from the literature forty-five case histories and showed twenty-five males, with an average age of about three and one-half months.

Prior to this date, no doubt, most all duo-

denal ulcer of infancy was called melena neonatorum, or congenital pyloric stenosis. It should be noted, however, that the latter occurs in the first few weeks of life and duodenal ulcer usually around the third to sixth month.

X-Ray has only recently been used on these cases and its details are not yet standardized, but it will probably play an important role in its diagnosis in the future.

To summarize the Roentgen signs of duodenal ulcer, we may classify them as follows:

- A—Direct signs under which falls actual deformity of duodenal contour.
- B—Indirect signs under which we find—
  1. Alterations of gastric tone.
  2. Alterations of gastric peristalsis.
  3. Alterations of gastric motility.
  4. Gastric spasm.
  5. Tenderness localized to the duodenum.

I believe we may safely assume that Roentgenology in the diagnosis of duodenal ulcer holds the most prominent place of all our present methods.

### ULCERS OF THE STOMACH AND DUODENUM, THEIR SURGICAL DIAGNOSIS\*

Ralph H. Chaney, M.D.,  
Augusta, Ga.

The recent development of roentgenological diagnosis of gastric disease has had a tendency to make us prone to slight many of the time tested methods of arriving at correct diagnosis by other means. Thus prior to considering the surgical therapeutics of the problem I desire to review some of the factors which should be considered in making or excluding the diagnosis of gastric or duodenal ulcer.

When we consider gastric or duodenal ulcers which form the most common lesions of the region, it is well to recall that the stomach is differentiated as one part of the foregut from the other which forms the duodenum to the ampulla of Vater, the foregut terminating at the entrance of the ducts from the liver and pancreas into the duo-

\*From the Department of Surgery, Medical Department of the University of Georgia.

\*Read before the Richmond County Medical Society, January 16th, 1925.

denum. The section of the foregut which forms the stomach is separated off from that portion forming the upper portion of the duodenum by the circular ring of muscle forming the pylorus by the end of the second month of fetal life. In the adult, differentiation of the stomach from the duodenum is easy, for the pylorus is easily felt and furthermore, exactly at the pylorus a thin, white line exists which is exceptionally clear cut in the living subject. Close to this white line lies the pyloric vein, which tho it varies considerably as to the number of its channels is constant in its position in 90% of instances, making a rather accurate landmark.

Ulcer occurring proximal to the pyloric vein is gastric, while that occurring 0.75 to 1.25 cm. beyond is duodenal. It is important to distinguish these forms as the symptoms of each tend to differ and their sequela vary in respect to perforation and hemorrhage. Cancer frequently develops in gastric ulcer, but practically never appears in association with duodenal ulcer. Thus while cancer of the duodenum is rare, it practically is never associated with coexistent ulcers, but on the other hand, it is not an uncommon finding to find three to five ulcers existing in the body of the stomach, one or two of which will show cancer and the others be absolutely benign. The final necessity for the differentiation is that surgery may be optional in the case of duodenal ulcer while it is almost imperative in gastric ulcer.

Gastric ulcer in comparison with duodenal ulcer is relatively rare. Its diagnosis is difficult for it is frequently mimicked by other conditions which are purely functional. The statement which occurs so commonly in text books to the effect that the diagnosis is easy rises because of the many instances in which a diagnosis of ulcer has been improperly made and not confirmed by x-ray or operation.

Gastric ulcer occurs twice as commonly in men as in women, while duodenal ulcer occurs more equally in both sexes. In both sexes four to five duodenal ulcers will be found for every gastric ulcer. The chief symptom is pain, the main attribute of which is regularity, with varying periods of remission. These periods of remission may be long or short or may occur at varying

times of the year, but with the attack pain is the dominant factor and shows regularity. It does not tend to skip one meal and occur after another, nor does it skip one day to appear the next.

The interval between the meal and the pain is fairly constant, the earlier the pain occurs following the meal, the closer the lesion is to the esophagus. If the pain comes regularly one to one and a half hours after meals, the ulcer is in the prepyloric region of the stomach, while if the pain arises two, three or four hours after the meal, the ulcer lies beyond the pylorus. The period of relief from pain following meals is constant and invariable in both gastric and duodenal ulcers until perforation, stenosis or formation of perigastric adhesions take place. Any of these conditions alter the appearance of the pain, usually in gastric ulcer they tend to delay the onset of pain, while in duodenal ulcer they hurry the onset of the pain. Three out of five cases of gastric ulcer operated upon show pain within one and one-half hours after food, while more than four out of five duodenal ulcers show pain two or more hours following food. The pain of gastric ulcer is relieved or disappears after an hour or less and remains absent until after the next meal. Duodenal ulcer pain persists increasingly after its onset until food is again taken.

The character of the meal definitely influences the type of pain in these ulcers. A full meal of heavy food causes an earlier appearance of the pain in gastric ulcer, but delays the appearance of the pain in duodenal ulcer. Indiscrete and hasty meals of fruits, salads or pastry may cause instant severe pain in gastric ulcer, but produce little discomfort in duodenal ulcer and in fact can lessen the duration of the pain.. The use of bland diet taken at frequent intervals tends to bring improvement in all. In a relatively small proportion of cases the pain is not influenced in any way by taking food, the nearer the lesion to the cardia the less the relief from pain after food and the greater the probability of acute pain occurring at once following food intake.

The pain is boring, burning or gnawing. In gastric ulcer it is usually to the left side and high in the mid portion of the epigastrium, while in duodenal ulcer it is usually



only mid-epigastric. Where the pain occurs in the back it usually indicates that the ulcer has perforated onto the pancreas.

The position of the ulcer, the degree of freedom from adhesions, and the size of the ulcer all affect the type of the pain, the duration of its latent periods and the time of pain onset after meals. Those ulcers which are small and high on the lesser curvature or posterior wall of the stomach have symptoms which are shorter in duration, but they are more apt to recurrence and often are attended by severe local spasms which are responsible for the sensations of distension, weight and pressure, so much more prevalent in this type than in the other forms of ulcer. Where the ulcer burrows onto the liver, pancreas or is fixed by adhesions the symptoms are much less likely to be remittant. Thus when a history of remissions is obtained which are becoming shorter in duration it is probable that one of the above mentioned conditions has taken place. However, where anemia and wasting are present the question of malignancy should always be considered.

The pain of ulcer of the stomach or duodenum is relieved not only by food, but by the alkalies, the carbonates and the like. It is also relieved by vomiting and lavage of the stomach. Not infrequently a patient finds that lavage will relieve the pain and learns to wash out his own stomach thus producing temporary relief during the periods of his attacks. The fact that food lessens the pain accounts for the fact that many patients do not lose weight during an attack and even in some instances will gain in flesh.

Twenty percent of all cases will have prostration, lassitude and feebleness coming on just prior to the period when the pain is due, and in some cases these symptoms will precede the coming of the pain by weeks or months, but the periodicity of the symptoms is just as exact as is that of the pain which follows. Pain in its occurrence, sequence and relief is the most important factor in diagnosis.

Next to pain in importance as a symptom is vomiting, both in respect to value and frequency. In all forms of ulceration in-

volving the stomach and duodenum, vomiting is inconspicuous unless the ulceration has produced obstruction as a result of cicatrization. Obstruction may be of marked degree without vomiting arising, in all probability due to the fact that the patient learns how much his stomach will tolerate and does not overstep the limit. As a rule vomiting is much more frequent as a self-induced symptom early in the course of the disease, the patient having learned that by this means he is able to overcome to some extent the sensations of pressure and distension. When a patient comes suffering from a dyspepsia with frequent vomiting and inability of the stomach to tolerate food or even liquids, gastric ulcer as a cause of his trouble should at once be abandoned, for this type of history practically never produces organic disease of the stomach. Vomiting when it occurs in ulcer is always a symptom occurring late after taking food.

Hemorrhage from the stomach in association with gastric ulcer occurs much less frequently than is commonly supposed, probably in less than 25%. The amount of blood lost thru a gastric ulcer is generally trivial, even tho its persistence may cause the development of a marked grade of anemia. The general assumption that when either bright or dark blood is vomited in large quantities ulcer is present, often is fallacious. While gastric hemorrhage often occurs in profuse amounts, and can so occur in ulcer, the other conditions which more commonly cause such hemorrhage are so numerous that ulcer should not at once be labeled as the cause. Splenic anemia, primary anemia, cirrhosis of liver, appendicitis or any infective condition of the abdomen may be the cause of profuse gastric hemorrhage. When no other symptom pointing to ulcer is present, these other conditions should be considered as causative factors first, even tho a few ulcers have the first symptom of their existence manifested by profuse hemorrhage. Not infrequently in patients dying from gastric hemorrhage small cracks or fissures will be found in the gastric wall at autopsy. These lesions are never surgical. The ulcer causing symptoms and repeated attacks of indigestion is always a gross lesion, which shows destruction surrounded by a defensive



inflammatory reaction and extending thru the wall so as to produce changes in the serous coat.

Physical examination reveals little or nothing save in the presence of an obstructive lesion. Tenderness to palpation is about the only finding in the absence of obstruction. Ulcers of the lesser curvature sometimes show marked tenderness high upon the left side along the costal margin, this tenderness frequently becoming acute as the patient breathes. The huge stomach with slow, powerful peristaltic contractions when stenosis is present should be easily recognized.

From the surgical standpoint gastric chemistry gives but little aid, only 40% of cases showing a hyperchlorhydria while from 15% to 20% show an actual decrease from the normal accepted standard. Moynihan lays but little value upon the value of hypoacidity or hyperacidity but points out that five general deductions may be drawn. First, a high free hydrochloric acid content supports the diagnosis of ulcer, tho it may exist in a pure functional condition or in association with a small cancer at the pylorus. Second, the absence of free hydrochloric acid or a marked diminution of it, supports the diagnosis of cancer, tho this again may be the symptom of a pure functional condition. Third, the absence of lactic acid does not rule out cancer but its existence gives strong support in making such a diagnosis. Fourth, a greater secretion of hydrochloric acid following the test meal than exists after the motor meal indicates either a healthy stomach or an ulcer. Fifth, the presence of blood is indicative of an ulcerative process either malignant or benign.

The final diagnostic check is by means of the roentgenological examination in regard to which I desire to stress only a single point, namely, that the existence of retention following the ingestion of a heavy barium cereal meal is indicative of some organic lesion of the stomach provided that the coexistence of a migraine attack at the time of examination is ruled out.

Careful diagnostic methods will indicate the rarity of gastric and duodenal ulcers and reveal the host of other conditions formerly

termed ulcer improperly. Not infrequently cholecystitis and chronic appendicitis start with symptoms entirely gastric, and it is not uncommon to find in examining the stomach of cases of chronic appendicitis a spasm of the stomach and a reddish pyloric blush, but no actual lesion of the stomach will be found. Gastroenterostomy in such cases is simply the forerunner of digestive disaster, which justly warrants the illhumor on the part of the internist to whom these individuals go after leaving the surgeon.

From the pure surgical point of view, it is my belief that all ulcerative lesions of the stomach should be treated surgically, not that the medical cure of these lesions is impossible, but that at present we are unable to distinguish between early simple ulcers and early carcinoma. From the roentgenological standpoint we are unable to differentiate between a malignant ulcer and a simple ulcer until the crater of the ulcer has reached at least a diameter of one centimeter or more. Likewise after the ulcer is removed in many instances it is impossible without microscopic examination to determine the presence or absence of malignancy. Various authorities place the secondary implantation of malignancy on ulcer anywhere from 3% to 65%. My personal feeling is that implantation occurs but very rarely and that the malignant ulcer is malignant from the onset, for I have observed ulcers having a crater of only one to two millimeters in diameter which showed malignancy in all portions of the base and edge. In two of these instances I have seen death later occur from metastasis to the lung and spine without any evidence of local gastric recurrence. Duodenal ulcer, on the other hand, early in the course of the disease certainly warrants the attempt at arrest or cure by dietary measures, for benefit occurs in practically all cases. Nevertheless when these lesions produce obstructive symptoms or give signs indicating perforation they become surgical. Likewise the extreme rarity with which cancer strikes the duodenum makes palliation possible in a way that is impossible with gastric ulcers. The assumption of this measure of leniency in the treatment of duodenal ulcer often leads the surgeon to grief, for frequently his medical friends persist in their treatment long beyond the period when

the surgical indications arise and he is called upon by the pathology forced upon him to perform an extensive resection involving the pylorus with its higher mortality risk, when earlier cure could have been obtained thru some simple procedure.

The acutal surgery of ulcer of the stomach and duodenum will probably for a period yet be a matter of individual opinion. The general opinion is that gastric ulcers should be excised. Where this can be done without incroachment upon the lumen simple excision with an accompanying gastroenterostomy has given the best results in the hands of the majority of operators. Where the ulcer bearing area is large often sleeve resection is possible and in those cases of multiple ulcers of the pyloric region the Polya is suitable. In a very small number of instances the Bilroth No. 1 operation is applicable, the same being true of the recent operation of Shoumacher. In duodenal ulcer simple gastroenterostomy is probably the most uniformly successful operation, tho equally good results follow some type of pyloroplasty in the hands of other operators. The growing tendency to advise hemisection of the ulcer bearing area of the duodenum and pyloric end of the stomach in all cases of prepyloric gastric and duodenal ulcers, advocated in Europe by Moynihan and Schoumacher and in this country by Erdmann, Strauss and others, is certainly entirely too radical a procedure for general adoption. Even in the hands of Schoumach it has carried a mortality of over 3.5% against an average mortality of less than 2% for gastroenterostomy or pyloroplasty in the hands of all surgeons.

The rather general opinion among internists that the surgical treatment of ulcer is a failure probably rises due to the fact that they only see the cases that have difficulty following operative measures and do not come in contact with those who have obtained relief. Pool in reviewing the results obtained at the New York Hospital found that three causes exist for the majority of failures: First, the operation was improperly performed. Second, the operation was

wrongly elected. Third, that gastrotjunostomy is inevitably and inexplicably unsuccessful in a certain proportion of cases. The latter reason appears to me to be a "catch-all" group in which to place those cases which for failure of proper analysis or improper recognition of existing pathology are not placed where they belong.

Crile in tracing his cases shows a mortality of less than 1% where resections for malignancy are excluded and finds that 98% of his cases show cure or improvement. Scudder reports 92% of cases without any post operative symptoms, 8% complaining of recurring difficulty, half of whom show improvement under the proper dietetic measures. Deaver finds that 80% have complete relief, 16% show tendency to recurrence of trouble controllable by dietetic measures, leaving 4% who are not benefitted, half of these being due to the development of marginal ulcer. The Mayo Clinic reports 94% with complete relief, 4% with difficulty controlled by proper diet regulation and 2% showing no benefit from the operative measures.

The main reason for failure I believe from personal observation is due to the fact that the patient is allowed to pass from control without receiving the proper instruction in regard to diet and general personal care. A large proportion of gastric cases have associated disease in the teeth and lymphatic tissues of the nasopharynx and unless these focii are attended to, recurrence of symptoms is almost inevitable. The sooner we realize that surgery in the treatment of gastric and duodenal ulcer is only one of the means of arriving at the end toward which we are striving, namely, the cure of the patient, the sooner we will work hand-in-hand with the internist, thus giving our patients the proper dietary regulation which they must have during the critical period of readjustment which follows every gastric operation no matter how simple it may be. When this is realized the results of our treatment of gastric and duodenal ulcers will be greatly improved over the present method of either medical or surgical treatment.



# ACUTE APPENDICITIS, PERITONITIS (GENERAL), ILEO APPENDICEAL FISTULA

B. T. BEASLEY, M.D.  
Atlanta, Ga.

It did not occur to me that this condition was so rare until I noticed the report of a similar case in *The Journal of the A. M. A.* of March 14, 1925, by Andries and Marks. They were not able to find any case reported. Willour in July, 1923, reported a similar case in *The Journal of the A. M. A.*, and found three other cases reported at necropsy.

## Report of Case

W. B. S., male, age 33. Electrical contractor; weight 155 lbs., height 6 feet. Family history and past history negative.

He was awakened at 2 A. M. with severe pain in abdomen "all over." He says he was very sick even in his feet. He got up and took hot salt water and an enema, vomited and got a bowel movement, but was not relieved. At 6 A. M. he took hot castor oil and bowels acted in 30 minutes and was relieved temporarily. He left for his usual uptown duties at 7 A. M. The pain returned shortly and forced him to go home about noon. He didn't vomit any more.

He was seen by me at 1:30 P. M., and upon physical examination his abdomen was observed to be rounded and rigid, very tender to pressure with most tenderness, however, over the region of the appendix. He was sent to the hospital and after a short consultation with Doctor T. C. Davison he was taken to the operating room. The abdomen was entered through a right rectus incision nine c.m. in length and found full of serous fluid. General peritonitis had developed. The appendix was delivered and inspected. It was abscessed, directed upward in front of the ileum and adhered to it firmly about the distal third near the caecum. A well established fistula was observed between the appendix and ileum when adhesions were divided. The appendix was removed in the usual way and the fistula in the ileum closed with Lembert suture and at the suggestion of Doctor Davison the abdomen was flushed out with a gallon of iodine solution (1 oz. iodine to 1 gallon sterile water). Drainage was provided and the wound closed in the usual way.

The patient made an uneventful recovery.

# BREATH SOUNDS OVER MASTOID CELLS

John R. Lewis, M.D.  
Louisville, Ga.

I have noted with interest that breath sounds are heard normally over the mastoid cells. This fact I feel sure many men are already aware of. The type of breath sounds normally heard are of a vesicular bronchial type in order stated: A predominating vesicular wave and a short bronchial wave; that in a diseased mastoid with impairment you get a different type of breath sounds; that in a mastoid with fluid or pus you get a type of breath sounds like you get over a consolidated lung area. This I believe has some significance, especially to the busy practitioner that has not ready access to an X-ray, etc.

I feel confident that bearing the above facts in mind one can determine whether it will be likely necessary to operate on a mastoid or not. Any observations by other men I would appreciate. If I am wrong I am desirous of correcting myself. If I am right, and I believe I am, I want to study the above sign even more closely and extensively.

## DISCUSSION ON PAPER OF DR. M. M. McCORD\*

DR. JOHN M. POER, West Point, Ga.: The pendulum swings from year to year. Up to a few years ago I always confessed that as a general practitioner I knew very little about feeding babies. If they could not take the mother's milk, if it was upsetting, they were referred to the specialist because I thought they were better able to advise them. I would often be very much surprised to have these specialists say, "Why do you give condensed milk, the child will have rickets." "Why do you boil the milk? The child will have rickets." "Why do you give them patent food? They will all have rickets." Then the mother would come home thinking that the home physician did not know anything—and he didn't know much. Now we have the specialist talking for dry milk. I am one who claims that the milk should be boiled in the Southern States. If I find anything that will do good I am willing to use it. This dry milk has

Dr. McCord's paper, "Report of 2,000 Infants Fed on Dry Milk," was published in last month's *Journal* (August), page 316.



the advantage that it does not need ice to keep it. Dr. Holt demonstrated years ago that we could take cow's milk and boil it and put it in a bottle and cross the ocean and still have the milk fit to feed a baby. Sterilization of milk has been recognized for a long time as a good thing. We give orange juice in connection with this sterile milk. I would not depend upon a nurse, the best obtainable, to keep the milk good unless it was sterilized and put on ice. I have had others come to me and say, "That prescription you gave me to sterilize the milk and sterilize the bottle would take all my time. I can put a few drops in and stir it up and give it to them." The mothers learn about these little things like condensed milk and send to the store for it. The doctors should use modified milk for in this way they are more likely to hold the patients than if they send them to the store to get dry milk that they can mix with water and give themselves.

I agree that the condensed milk is often better than cow's milk and that the "Dryco" is a good preparation. Many of these things will act well in one case and not in another. Until the stomach can be adjusted and get back to the modified cow's milk we may have to use a little condensed milk or "Dryco" but I think the pediatricians should stick to modified cow's milk.

DR. R. L. MILLER, Waynesboro, Ga.; I wish to congratulate Dr. McCord on his brilliant results in such a large number of cases. I have been taught to look upon dry milk as being about as suitable for a baby as I would be as a wet nurse, but Dr. McCord has knocked that belief into a cocked hat by his paper this afternoon. However, as brilliant as his results have been, I do not think I can give up the lactic milk, nor can I give up the use of protein milk in feeding some of these babies.

DR. H. C. WHELCHER, Douglas, Ga.; Just one or two points that I wish to mention. I do not quite agree with the Doctor in feeding by the age of the baby. I think it is better to feed by weight. I agree with the idea of giving so many calories to the pound of body weight. I have had only a little experience with the dry milk, not with "Dryco" at all, but we all agree that mother's milk is the best of all food for the baby. The next best is cow's milk, modified as nearly as possible to the mother's milk.

The point I wish to make is that I think it better to feed according to the weight of the baby than according to the age of the baby.

DR. W. A. MULHERIN, Augusta, Ga.; There are some good men who use dry milk,

but I think the majority do not use dry milk. Dry milk has its sphere of usefulness, and especially would the man be sensible and practical if he uses it for the baby out in the country where there is no ice, and no good milk supply. Under those conditions I think it is very wise to give dry milk. If a mother is going to take a railway trip she should use dry milk and not feed milk that is obtained at different points along the line. I have watched the thing very carefully and am not prejudiced, but I cannot get the same results in babies that I can with other milk. "Dryco" is made from 2 per cent milk and I do not know how it can cure rickets. Rickets is not always detectable by the rosary or by the x-ray findings. I am not speaking against dry milk, except to remind you that sometimes temporary success means ultimate failure. We have not tried the dry milk sufficiently. Five years ago we knew practically nothing about the vitamins. Now we know quite a good deal about them and five years from now we may know more about dry milk.

I strongly believe in boiling the milk. If I lived in New York and got the Walker-Gordon milk I would still recommend boiling the milk.

Today the principle of artificial feeding has changed considerably. At one time we could not give a child cow's milk without adding water to bring it to the taste of the baby. Today we know why a baby cannot digest full strength cow's milk as well as mother's milk. We know it is due to the salts, the buffer milk. If we neutralize that we can give the babies pure milk and can add the cane sugar, which gives rise to very little fermentation. We recommend the lactic acid milk with Karo syrup and we use this on the prematures, and on new-born infants. If you once start using it I think you will find it very hard to beat.

Gain in weight is not the only evidence that a child is thriving properly. It is the appearance of the child, the muscular tone, the bony structure and the happy condition of the baby that tells the story. You can fatten the infant but you have to look to the fats to make bone and general heat. The proteins will make the cell proliferation and the muscular tone, and the food must combine all of these.

DR. THOMAS R. GAINES, Hartwell, Ga.; I am a general practitioner and in the five years I have been in practice it has been impressed upon me very forcibly that the doctors tell the mothers to mix milk and water and add sugar to taste and feed the baby. Under those circumstances I think we cannot expect the mothers to have much faith in their physicians. I think the physicians

should have a baby of their own when they give such advice. I had this experience and after sitting up several nights I found it advisable to do something else. An old friend loaned me a book of Dinet's (?) and I read it. Then I fed cow's milk, water and dextrimaltose. My baby got along splendidly and several mothers saw how well it looked and came around and wanted me to take care of their babies. I had wonderful success in about twenty-five cases and felt so good about it that I read a paper before the County Medical Society on the Dinet treatment, or method of feeding. Then I had a failure and finally put that baby on "Dryco." I think we can feed 90 per cent of the babies satisfactorily on these things. If it is not satisfactory try the lactic acid milk and karo syrup, the "Dryco," or whatever you like. If you are dealing with an intelligent mother and give them routine, written instructions, you can get good results in 95 per cent of the cases.

DR. WILLIAM L. FUNKHOUSER, Atlanta, Ga.; I am very glad to hear the doctors discuss this subject. We have at our disposal modified cow's milk, dry milks, re-constructed milks, lactic acid milk and many more; we need them all and more to successfully feed our difficult cases. I think in cases where we are unable to get good results with good cows' milk, or unable to get good cows' milk, the dry milk has a definite place in our food. In our clinical work at the Grady Hospital, and in the department where we take the babies from the hospital after delivery, when we know that these colored mothers are not able to get good, fresh cows' milk, we use the dry milk with very satisfactory results.

My idea is that we should teach the modification of cows' milk, and we should practice it, but we can use the dry milk diluted to the strength necessary. A tablespoonful to the ounce is equivalent to whole milk. Starting with whole milk dilution we can then make such modifications as we know are advisable by our methods of modifying fresh cows' milk. We can replace the deficiency in fat by giving cod liver oil, particularly in the winter time, and by adding other vitamins. The Kline has the advantage of dry milk in that it can be made up for the day. While dry milk is of great value I think it is not a panacea. We need all the methods we have to solve some of our difficult problems.

DR. T. W. AYRES, University of China, Shantung, China, (by invitation): I have been intensely interested in this milk question because we have to struggle with it not a little in the hospital where I work. We have tried three plans in feeding a very large number of Chinese children. I do not know whether the stomach of the Chinese child is just like that of the American baby but think there is not much difference. We tried first the modified cows' milk. Second, we tried the dried milk and, third, we have tried the modified Swiss goats' milk, and after experimenting with these three foods for several years we have found that we get much better results from the modified goats' milk than from anything else. In that hospital now we keep a little herd of Swiss goats and we get much better results from the modified goats' milk than from either the modified cows' milk or the dry milk. I only wish to make this suggestion and if you have the good fortune to get a good Swiss goat try its milk in these cases.

DR. M. M. McCORD, Rome, Ga., (closing): I want it distinctly understood that I am not against modified fresh milk. I use it every day but the point I tried to make clear was that there are many homes where they cannot carry out the directions for modifying milk. We do not all have wealthy mothers to deal with who can get the lactic acid milk, or intelligent mothers who can carry out the other directions. If they all had ice all day long it would be all right, but in the homes where they have ice only half the time, where they are not intelligent enough to carry out directions and where we need something that is easily understood we find this of great benefit. They can carry out the necessary instructions concerning this without difficulty. They can buy any kind of milk. If they are in New York, Philadelphia, Boston or Chicago they can get the Walker-Gordon milk and there is no difficulty. It is the people who have ice only a few hours a day and no means of taking care of it, the people who get poor milk, who need the benefit of this. I visited a home yesterday morning where they were delivering milk that was supposed to have been milked that morning and it was already beginning to sour. It is in the cases like that that the dried milk is of such great advantage.



# THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Profession of Georgia.

65 Forrest Ave., Atlanta, Ga.

SEPTEMBER, 1925

ALLEN H. BUNCE, M. D., Editor

Publication Committee

CHAS. USHER, M. D.

S. J. LEWIS, M. D.

T. C. THOMPSON, M. D.

Articles are accepted for publication on condition that they are contributed solely to this Journal.

Manuscripts should be typewritten, double-spaced, and the original (not the carbon copy) submitted. Used manuscript is not returned unless requested.

Communications and items of general interest to the profession are invited from all parts of the State. We especially invite county society secretaries to send us information of happenings in the county that would be of interest to the members throughout the State.

Reprints should be ordered within 30 days after the appearance of an article, since all type will be destroyed at the end of that time.

## Editorial Department

### TWO MESSAGES FROM OUR PRESIDENT.

#### Register and Vote!

This is the time of year, just before municipal and other primaries and elections, when citizens are reminded of the importance of registering, and later are urged to vote. How many members of the Medical Association of Georgia will register and vote this fall? At a medical meeting in one of our cities recently, a few days before the registration books were closed, the question was asked how many members were registered, and the answer was less than fifty per cent.

The doctors of any community rightfully are regarded as among the most intelligent and best educated residents of the place. If the leading citizens of a town or county do not take enough interest in local and national government to devote a few minutes to voting for candidates and measures which they consider valuable, how can they expect good candidates to be chosen for office, or wise laws to be enacted?

It is argued that high class men no longer

offer themselves for public positions in our elections. This may be true in some instances, but if our substantial business and professional men will call on good citizens to run for office, and will go out and vote for them, the complaint often heard that we are governed by inefficient and unscrupulous office holders no longer will be justified.

Frequently medical men and other worthy persons who do not exercise their privilege of voting are the severest in their denunciation of certain officials and their acts. Any member of society who has the right to vote and fails to do so certainly should not find fault with a government which by his indifference he has failed to assist.

Some time ago a leading physician was heard to speak very vehemently against the issuance of certain bonds which soon were to be voted upon. So effective was his argument that all his hearers were won over to his way of thinking. Unfortunately for him, however, some one asked him was he going to vote against the bonds, and he was forced to admit that he had failed to register and could not vote. Immediately it was seen that all his argument was nullified. Anything else he said on the subject had no weight and fell flat.

Just now in Georgia, as well as all over the country, the medical profession, ever striving to prevent disease, is intensely interested in furthering important public health propositions which are in the hands of legislators to defeat or put into effect. It should be our duty, therefore, wherever we live, to use our vote and influence to elect men to office who are in sympathy with the great cause of the prevention and control of disease.

Before voting for candidates for our General Assembly and for county officials, the members of the Association should learn if possible how such candidates stand on public health matters and other things pertaining to the practice of medicine in Georgia. One way to accomplish this would be through the secretary of the county society or through a committee appointed by the president. Unless we adopt some such plan and vote accordingly, it will be a long time before Dr. Abercrombie and his able staff will have all the help they request for ear-



rying out a public health program needed by the state.

Some doctors may think it is beneath their dignity to mingle with the jostling, noisy throng at the polls on election day. Any one who cannot stand this belongs in an unlimited monarchy, and not in a republic. To be allowed to vote is the great privilege and glory of American citizenship. It is the thing our forefathers fought and died for. And the polls are much sweeter now with the advent of the ladies.

#### REGISTER AND VOTE!

#### The Physician's Claims Under the Federal Tax Reduction Plan.

Members of the Association who fail to read the Bulletin of the American Medical Association miss a great deal that is interesting and important to the profession. One of the most valuable articles appearing recently, in the June issue, has the above title, written by Dr. W. C. Woodward, Secretary of the Bureau of Legal Medicine and Legislation of the A. M. A.

In this article Dr. Woodward goes into considerable detail to present a clear and forceful argument why the medical profession is entitled to relief in three instances, under the proposed federal tax reduction plan, as follows:

First, the tax under the Harrison Narcotic Act should be reduced or eliminated. The original cost to physicians registering under this act was one dollar per year. In 1918 the tax was raised to three dollars to help meet the expenses of the government during the war. The tax is now costing the medical profession of the United States \$300,000 per year. This year it is estimated there will be a surplus of \$290,000,000 in the federal treasury. The government no longer has need for \$300,000 paid by the physicians. All other war taxes have been reduced or abolished; certainly this tax should take the same course.

Second, physicians should be allowed to deduct from their income tax returns the expenses incurred in attending the meetings of medical organizations. It is held that the travel of a physician for the purpose of keeping his professional knowledge and skill up to date is as much a part of the

practice of his profession as is the travel of a manufacturer or merchant, in person or through his representatives, for the purpose of keeping his plant and stock up to date, and if the expenses of one be deductible, the expenses of the other should be also.

Third, physicians should be allowed to deduct from their income tax returns the expenses incurred in postgraduate study. There is no direct tax on postgraduate study. The physician is not permitted, however, to deduct the expenses of postgraduate study in computing his federal income tax. The result is, in effect, a tax on such expenses.

It is hoped that every member of the Medical Association of Georgia will study Dr. Woodward's paper carefully and use his influence with our senators and representatives in congress to support this fair reduction in taxes on a class of citizens whose every effort is for the relief and welfare of humanity.

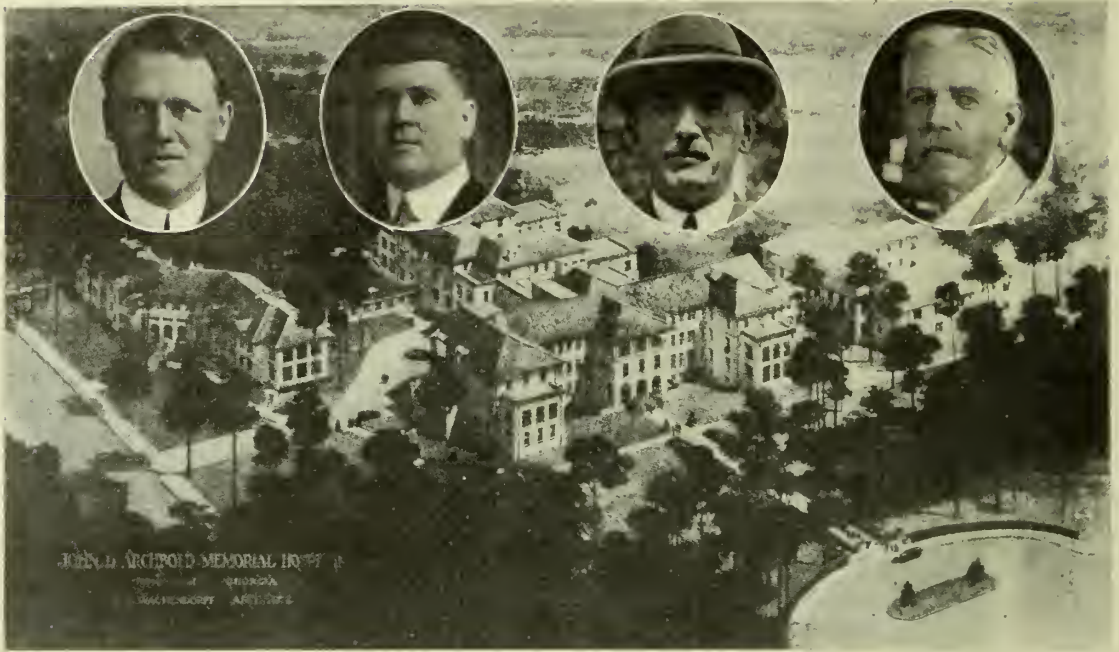
These matters come up for action by congress this fall. Urge your senator and congressman to show justice to the medical profession.

FRANK K. BOLAND, Pres.

#### THE TULANE UNIVERSITY OF LOUISIANA GRADUATE SCHOOL OF MEDICINE.

In a letter from Dr. E. Denegre Martin, Dean of the Tulane Graduate School of Medicine at New Orleans, Louisiana, he states that "The Graduate School of Medicine of Tulane has been thoroughly reorganized to meet the requirements of the Council on Education of the A. M. A. The Faculty has been enlarged by the addition of new men in all of the departments; clinics have been enlarged by taking over Touro which will give us work in the great Charity Hospitals, Touro and Senes. With these Hospitals at our command we are prepared to teach any of the branches and to furnish clinics as no other hospital in the country can give."

In an enclosed bulletin which was sent us, one can readily see that this would be an ideal school for taking post-graduate courses in any subject. For further information see their ad which appears in this Journal.



The John D. Archbold Memorial Hospital, Thomasville Ga., as it will appear when completed

Speakers at dedication exercise, left to right: 1. E. R. Jerger; 2. Dr. A. D. Little; 3. Col. James L. Bevans; 4. Judge H. W. Hopkins.

The following is the official staff of the hospital:

#### The Board of Trustees

Archbold, J. F.  
Chapin, Mrs. C. M.  
Cooper, M. M.  
Culpepper, J. T.  
Harvey, Mrs. P. W.  
Hollis, Fred  
Hopkins, H. W.

Jemison, J. B.  
Jerger, E. R.  
Lester, Miss Lucy  
Lewis, G. E.  
MacIntyre, W. F.  
Merrill, J. H.  
Merry, H. H.

Pringle, D. R.  
Simpson, C. A.  
Tillman, C. T.  
Vereen, W. J.  
White, Rev. Robb  
Williams, Mrs. Homer  
Wright, Miss Julia

Ex-Officio

Pardee, Mrs. R. S.

Bevans, Col. J. L.

#### The Women's Board

Driver, Mrs. L. F.  
Forbes, Mrs. G. W.  
Hayes, Miss Louise  
Jerger, Mrs. L. H.

Neel, Mrs. Clyde N.  
Pardee, Mrs. R. S.  
Phillips, Mrs. J. L.  
Pringle, Miss Nell

Singletary, Mrs. W. M.  
Steyerman, Mrs. Lou's  
Watt, Mrs. Hansell  
Wimberley, Mrs. Eunice

#### The Staff

Ainsworth, Harry  
Andrews, Agnew  
Cheshire, S. L.  
Erickson, M. J.  
Ferguson, C. H.

Hill, Roy  
Jarrell, W. W.  
King, J. T.  
Little, A. D.  
MacLean, E. K.

MacIntosh, T. M.  
Moore, H. M.  
Reid, J. W.  
Wall, C. K.  
Watt, C. H.

#### Director

Col. James L. Bevans



## THE JOHN D. ARCHBOLD MEMORIAL HOSPITAL, THOMASVILLE, GA.

Over five hundred people from all parts of Georgia and Florida were present at the dedication of the John D. Archbold Memorial Hospital at Thomasville, Georgia, June 30, 1925.

The exercises were held on the balcony leading from the Nurses' Home to the main building. On the platform were the speakers, the ministers who took part, the Board of Trustees and Officials representing the State Board of Health. The balcony had been decorated with vines and flowers, making a perfect bower of beauty looking over the driveway and inner court, which had recently been sodded with Bermuda grass.

The Thomasville Choral Society, composed of thirty-five voices, rendered two selections during the exercises—"Festival Te Deum" and "Praise the Lord, O Jerusalem."

After the invocation by Rev. H. T. Freeman, a beautiful prayer that the institution might prove of benefit and usefulness throughout the years to come and asking the blessing of God upon him, who gave it, and his family, the presentation of the hospital was made on behalf of Mr. Archbold by Mr. E. R. Jerger, tendering it in love and in the hope that it would prove of benefit and great service to the people that the donor so loved.

Dr. A. D. Little presented to Mr. Archbold in behalf of some of the citizens a wonderful portrait of the late John D. Archbold, his father. Dr. Little expressed great gratitude and love for the donor and respect and admiration for the character and benefactions of the man, whose portrait it was. Dr. Little has been largely instrumental in assisting Mr. Archbold in making this the institution it is and Colonel Bevans expressed the thanks of the entire community to him for his service in that regard.

Judge H. W. Hopkins, President of the Corporation, accepted the gift on behalf of the Board of Trustees and through them of the people of Thomasville. He made a most brilliant and interesting address in which he showed that this was one of the most magnificent and useful institutions that had ever been erected in Thomasville or South Georgia and spoke with much feeling

and love of the character and the interest of the donor, whose gift was unsolicited, an expression of a desire to benefit humanity and to give something to the betterment and the wholesomeness of human life. Judge Hopkins also read a telegram from Governor Walker, expressing gratitude on behalf of the State for this remarkable gift to its people. He announced the appointment of Mr. Archbold as a member of the Governor's Staff in recognition on the part of the State of his remarkable service to its people.

The benediction was rendered by Rev. Robb White, Jr. Colonel Bevans, who most graciously acted as master of ceremonies, then made the announcement of the visitation. The hospital was open for visitors all during the day until ten o'clock that night. The crowd was handled beautifully. There were several policemen on duty, together with the Boy Scouts.

The institution contains the most modern and improved equipment that can be secured. Nothing has been spared to create both beauty and utility. It was built at a cost of a million dollars, the silver alone amounting to four thousand dollars. The x-ray department is said to be the equal of any erected in the entire country. The laboratory is perfect in its location, size and equipment.

On the morning of the dedication practically all of the organizations in Thomasville sent telegrams of appreciation to Mr. John F. Archbold, expressing gratitude for the gift that will mean so much to their territory and of personal love for him.

The stores and business houses of Thomasville all closed during the morning from ten-thirty to twelve-thirty so that the owners and employees could attend the exercises. Sidewalks, business and residential sections were decorated with flags, giving the city quite a gala appearance for this momentous occasion.

The members of the Thomas County Medical Society entertained the visiting doctors and their families at a luncheon. Barbecue and fried chicken were in abundance.

The Medical Association of Georgia extends to Mr. John F. Archbold its grateful appreciation of the John D. Archbold Memorial Hospital, the finest in the country.



## District and County Societies

The Secretary of each county society shall report to the Journal of the Medical Association of Georgia full minutes of each meeting and forward to it all scientific

papers and discussions which the society shall consider worthy of publication.—Constitution and By-Laws, Chap. VII, Sec. 15.

1. McGee, H. H., Savannah.
2. Wood, A. W., Albany.
3. Greer, Chas. A., Oglethorpe.
4. Williams, C. O., West Point.
5. Fitts, Jno. B., Atlanta.
6. Hawkins, T. I., Griffin.

7. McCord, M. M., Rome.
8. Carter, D. M., Madison.
9. Bennett, J. C., Jefferson.
10. Lee, F., Lansing, Augusta.
11. Penland, J. E., Waycross.
12. Cheek, O. H., Dublin.

### HONOR ROLL

The following is a list of 100 per cent counties for 1925. The date on which each became a 100 per cent society appears after the name of the society, together with the name of the Secretary:

1. Randolph County, Dr. G. Y. Moore, Cuthbert, December 9, 1924.
2. Dougherty County, Dr. J. A. Redfearn, Albany, December 10, 1924.
3. Pike County, Dr. M. M. Head, Zebulon, December 12, 1924.
4. Hart County, Dr. W. E. McCurry, Hartwell, January 3, 1925.
5. Warren County, Dr. A. W. Davis, Warrenton, January 14, 1925.
6. Monroe County, Dr. W. J. Smith, Juliette, January 14, 1925.
7. Lamar County, Dr. John M. Anderson, Barnesville, March 6, 1925.
8. Upson County, Dr. B. C. Adams, Thomaston, March 30, 1925.
9. Emanuel County, Dr. S. S. Youmans, Oak Park, May 5, 1925.
10. Stephens County, Dr. C. L. Ayers, Toccoa, May 11, 1925.
11. Turner County, Dr. J. H. Baxter, Ashburn, May 12, 1925.
12. Evans County, Dr. D. S. Clanton, Hagan, May 14, 1925.

### FIRST DISTRICT MEDICAL ASSOCIATION\*

On August 6th and 7th, being Thursday and Friday, a most interesting and successful meeting of the First District Medical Association was held at the famous De Soto Hotel, Savannah, Ga. The Georgia (Chatham County) Medical Society acted as host for the occasion. The attendance was large, about seventy physicians being present, representing all parts of the district and many distant points of the state.

\*Dr. H. H. McGee, the newly elected Secretary, also sent us in a report of this meeting, but it was received too late for publication.

The meeting for the scientific program was called to order by the President of the Georgia (local) Medical Society, Dr. J. K. Train, at 11:00 A. M., in the absence of the President of the District Society, Dr. B. B. Jones, of Metter, Ga.

The following program was carried out with the exception of a paper by Dr. F. K. Boland, who was unavoidably prevented from attending the meeting.

#### De Soto Hotel—10 A. M., August 6

Invocation, Rev. Silas Johnson, Pastor Trinity Methodist Church.

Address of Welcome, Dr. J. K. Train, President. Chatham County Medical Society.

#### Scientific Papers

"My Experience with Regional and Local Anesthesia," Dr. Cleveland Thompson, Millen.

"Acute Inflammatory Conditions of the Abdomen," Dr. F. F. Floyd, Statesboro.

"Observations on the Gallbladder," Dr. F. K. Boland, Atlanta, President State Association.

"Diagnosis," Dr. P. H. Smith, Glennville.

"Influence of Posture on the Development of the Child," Dr. Theo Toepel, Atlanta.

At 2:00 P. M., a recess was held for two hours. The physicians of Savannah individually entertained the visitors at their homes or clubs for luncheon and then drove them over Chatham County's picturesque roads.

#### De Soto Hotel—4 P. M.

Presentation of Cases:

Dr. W. H. Myers—Savannah.

Dr. J. K. Train—Savannah.

Dr. W. A. Norton—Savannah.

Lantern slide demonstration:

X-Ray Findings in Rickets and Scurvy, Dr. Robert Drane, Savannah.

Dr. William R. Dancy, of Savannah, and 1st Vice President of the State Association, made a talk on the "Relation of the District Association to the State Association." It was discussed by Drs. John W. Daniel, Sa-

vannah; Theo. Toepel, Atlanta; and R. L. Miller, Waynesboro.

It was decided to hold the mid-winter meeting at Millen.

Dr. Miller Byne, Waynesboro, was elected President of the Association; Dr. William R. Dancy, Savannah, 1st Vice President; Dr. B. E. Miller, Claxton, 2nd Vice President, and Dr. H. H. McGee, Savannah, Secretary-Treasurer.

The second day was devoted entirely to entertainment in the form of a mammoth fishing trip. The steamer Clivenden was chartered for the day. Every physician, both visiting and local who could possibly leave business made the trip and added to the happy throng. At 11:00 A. M. in response to "Let's go" the old engines began to throb and seventy-five care free Deciples of Aesculapius smiled with the satisfaction of one day of freedom at least from telephone, patients, wives, and kids. As the steamer headed down the Savannah River with evidences of the State Port's excellent shipping facilities on either side, the black and tan orchestras, struck up the familiar tune, "It Ain't Going to Rain No More." This warning was unnecessary, as the day was clear and the gentle cooling breezes from the ocean made it ideal for comfort and fishing. Historic Fort Jackson, and then the far famed Waving Girl of the Savannah Harbor were passed, and stories repeated of the romance connected with the latter. At the end of two hours, we landed at Daufuski Island where the supply committee captured fifteen large water melons for the thirty fishermen. A little later we anchored on the fishing drop in Calibogue Sound. Many went out in the small boats, which had been provided; others fished from the steamer; while still others impelled by the call of Father Neptune, and hoping for a mermaid or two, clothed themselves in smiles and nature's birthday garb, and swam in the refreshing waters. Probably twenty-five at one time enjoyed this pleasant pastime. While all this was happening, others enjoyed the music and various entertainments aboard. The life of the ship was the genial president of the Georgia (local) Medical Society, Dr. J. K. Train, who did much to entertain. Not the least among his ef-

forts was his attempt to cut adrift a fellow practitioner who sat peacefully fishing from a small boat tied at the steamer's stern. In his effort to free the little boat something slipped overboard and it was his majesty the president. With life preservers, ropes, hawsers and much lingual lassitude, he was rescued, none the worse for his experience, except a thorough wetting. He bore his baptism with subdued dignity.

Throughout the entire trip several embryo doctors served shrimp, sandwiches, soft drinks, and near beer. In due time a splendid fish dinner with water melon for dessert was also served. Unlike most fishing trips, this was a successful one.. Every one landed a splendid string of the finny tribe.

At five P. M. we weighed anchor and steamed for home, reaching Savannah about 8 P. M. The return trip was equally as entertaining as the outward one. The tide being low we could see, feeding on the edges of the sand banks the marsh hen, the marsh wren, the sand piper, the aigrette crane, and the large and small blue herons. Many of the latter were seen flying to roost in flocks. Occasionally an old 'gator would be seen to tumble from the bank into the water..

The negro orchestra supplied us with splendid string music and some vocal selections. Many of the profession were at times inspired to song and dance. As we approached the end of our journey everyone sang old Southern Melodies. The day was ideal; a very happy one. The arrangements were wonderful. Every wish was gratified. The committee composed of Drs. Wm. H. Myers, chairman, C. F. Holton, J. R. Graves, D. B. Edwards, J. V. Long and E. C. Demmond, deserved the unanimous vote of thanks and the three cheers rendered by the assembled multitude.

The membership of The Georgia (local) Medical Society, host on this occasion, is a unit, in the belief that much is accomplished in the promotion of interest in the medical assemblies, by having a reasonably short, spirited, and pithy scientific program, impelling concentration and attention, followed by a period of rest, relaxation and recreation. A group of physicians thrown together in the companionship of pleasure,

will serve the cause well, and promote a cooperative spirit in local and state organizations. Knowing thy fellow practitioner, will develop a better feeling, a closer alliance and a superior *Esprit de Corps* in the profession. Rubbing shoulders with the other fellow means working with him for the benefit of the Medical Association of Georgia and in promoting the lofty ideals of the profession at large.

The psychology seems to indicate that a medical meeting as a whole is uninteresting to the average physician. He hesitates to attend because all papers do not treat of the specific subjects in which he is interested. He forgets that general discussions in the meetings, and private ones with the more experienced men of the association develop unlimited possibilities in the acquirement of medical information. He overlooks the fact that association with others of the profession add tone and type. Hence, it seems necessary to have something to attract, something to please, something that places one mentally in a receptive mood. So will the most gratifying results be obtained. That's why the First District Medical Association intermingles a scientific program with one of recreation.

Those attending the meeting were:

Drs. J. E. Morrison, Savannah; A. A. Morrison, Savannah; R. E. Graham, Savannah; E. N. Gleaton, Savannah; Howard Exley, Savannah; Charles Usher, Savannah; John Daniel, Savannah; Henry Tippins, Savannah; Wm. R. Daney, Savannah; J. L. Hiers, Savannah; J. K. Train, Savannah; H. H. McGee, Savannah; G. T. Olmstead, Savannah; M. J. Egan, Savannah; Lee Howard, Savannah; E. C. Demmond, Savannah; H. L. Levington, Savannah; George Waters, Savannah; L. H. Williams, Savannah; G. H. Faggart, Savannah; C. G. Redmond, Savannah; R. V. Martin, Savannah, Herman Hesse, Savannah; J. K. Quattlebaum, Savannah; J. D. Gray, Savannah; L. A. DeLoach, Savannah; Edward Whelan, Savannah; Lawrence Dunn, Savannah; D. B. Edwards, Savannah; Dr. R. L. Miller, Waynesboro; Dr. C. E. Stapleton, Groveland; Dr. H. E. Ezell, Oliver; Dr. R. L. Tarver, Guyton; Dr. Theo. Toepel, Atlanta; Dr. L. F. Lanier,

Rocky Ford; Dr. H. F. Olliff, Register; Dr. B. E. Miller, Claxton; Dr. L. B. Royal, Girard; Dr. J. F. McElveen, Brooklet; Dr. B. A. Deal, Statesboro; Dr. Johnson, Estell, S. C.; Dr. C. Thompson, Millen; Dr. A. J. Mooney, Statesboro; Dr. Miller Byne, Waynesboro; Dr. T. W. Welborn, Hinesville; Dr. J. C. Collins, Manassas; Dr. Balser, Dr. J. C. Harris, Reidsville; Dr. F. F. Floyd, Statesboro; Dr. C. F. Holton, Savannah; Dr. L. B. Taylor, Savannah; Dr. George Touehnton, Savannah; Dr. Ralston Lattimore, Savannah; Dr. W. H. Myers, Savannah; Dr. Jas. R. Bean, Savannah; Dr. Walter Norton, Savannah; Dr. St. Julian deCaradeue, Savannah; Dr. A. J. Waring, Savannah; Dr. Bob Drane, Savannah; Dr. J. Jones, Savannah; Dr. E. C. Demmond, Savannah, Dr. J. R. Graves, Savannah.

W. R. DANCY, 1st Vice-Pres.

### RANDOLPH COUNTY MEDICAL SOCIETY.

The July meeting of the Randolph County Medical Society was turned over to Dr. T. F. Sellers, Director of Laboratory of the State Board of Health. He gave a most interesting talk on "Rabies."

The August meeting of our Society was held in the Woman's Club Room in Cuthbert, August 6, 1925. The following program was carried out:

"Relation of Veterinary Profession and Medical Profession"—Dr. F. D. Patterson, Jr., Cuthbert. Discussion by Drs. E. C. McCurdy, Shellman; J. H. Staples and F. S. Rogers Coleman.

"Vineent's Angina"—Dr. D. L. Smith. Discussion by Drs. Loren Gary, Georgetown; C. E. Wade, H. W. Taylor, F. M. Martin, Shellman.

"Osteomyelitis"—Dr. W. W. Crook, Cuthbert. Discussion by Drs. A. L. Crittenden, Shellman; H. R. Ingram, Coleman; F. D. Patterson, Cuthbert.

Report of Clinie at Arlington—Dr. J. C. Patterson, Cuthbert.

The September meeting was devoted to Cancer.

G. Y. MOORE, Secretary-Treasurer.



**BROOKS COUNTY MEDICAL SOCIETY.**

The members of the Brooks County Medical Society were hosts to the members of the Thomas and Lowndes County Societies on August 11, 1925, at the Quitman Country Club. The scientific program consisted of the following papers:

"Object of Meeting," Dr. G. D. Dorough, Quitman, President of the Brooks County Medical Society.

"Word of Welcome," Dr. E. L. Jelks, Quitman.

Response, Dr. J. M. Smith, Valdosta.

"Pyelitis in Children," Dr. E. K. McLean, Thomasville.

"Treatment of Goiter," Dr. T. C. Davison, Atlanta.

"Well-Timed Operative Procedure vs. the So-Called Emergency Operation," Dr. C. W. Roberts, Atlanta.

"Diagnosis," Dr. A. D. Little, Thomasville.

A talk by Dr. Frank K. Boland Atlanta, President of the State Association.

"Local Anesthesia in General Surgery," Dr. Chas. H. Watt, Thomasville.

Talk on internal medicine by Dr. J. A. McGarity, Atlanta.

"Adenoids and Some of Their Symptoms," Dr. John T. King, Thomasville.

After the program a delightful dinner was served at the Club..

**FULTON COUNTY MEDICAL SOCIETY**

An interesting meeting of this Society was held at the Academy of Medicine, 32 Howard St., Thursday, August 6th, at 8:00 P. M.

Dr. B. H. Wagnon presented a patient before the Society of "Granuloma Inguinale Treated by Intravenous Injections of Tartar Emetic." This case was discussed by Dr. Jack W. Jones.

Dr. W. R. Smith reported a case of "Perthe's Disease," which was discussed by Dr. E. C. Thrash. A case report by Dr. W. W. Young was given on the "Inseparability of the Psychical and the Physial." The clinical talk was of interest, on the subject of "Tetanus" as presented by Dr. E. D. Shanks. The paper of the evening was read by Dr. O. S. Cofer on "A Mid-Point in the Practice of Obstetrics." This paper was discussed by Drs. O. H. Matthews, M. T. Benson, E. C. Davis and R. A. Bartholomew.

Under New Business, Dr. E. D. Highsmith stated that a medical missionary in China doing wonderful work, had been promised assistance by the Carnegie Foundation Fund in buying an X-Ray machine contingent upon his being able to get half of the purchase price subscribed. In just a few minutes a very little sum was raised for this purpose by the members present.

There was no other business to come before the Society at this time, the motion being in order to adjourn.

Respectfully submitted,

GRADY E. CLAY, Secretary.

**WOMAN'S AUXILIARY TO THE FRANKLIN COUNTY MEDICAL SOCIETY.**

The Woman's Auxiliary to the Franklin County Medical Society was organized July 27, 1925, at the home of Mrs. Stewart D. Brown, Royston. The following officers were elected:

President, Mrs. Stewart D. Brown, Royston.

Vice President, Mrs. Joe Brown, Martin.

Secretary-Treasurer, Mrs. G. T. Ridgway, Royston.

The following are members:

Mrs. J. H. Terrell, Lavonia; Mrs. G. W. Whiteside, Lavonia; Mrs. W. B. Heller, Lavonia; Mrs. J. M. Freeman, Lavonia; Mrs. George Brown, Martin; Mrs. E. T. Pool, Carnesville; Mrs. C. B. Lord, Ashland; Mrs. B. T. Smith, Carnesville; Mrs. George Parker, Carnesville; Mrs. George Bush, Carnesville; Mrs. N. G. Williams, Canon; Mrs. S. D. Brown, Royston; Mrs. H. L. McCrary, Royston; Mrs. J. O. McCrary, Royston; Mrs. F. G. Moss, Royston and Mrs. G. T. Ridgway, Royston.

Delicious refreshments were served by the hostess..

**A CORRECTION**

Dr. W. P. Jordan, President of the Muscogee County Medical Society, and Acting Secretary in the absence of Dr. Francis B. Blackmar, called our attention to an error in the list of officers of his Society, which appeared in the July issue of the Journal. Dr. J. H. Pennington, Columbus, should have been named as Vice-President instead of Dr. J. C. Wooldridge, Columbus. Our mis-information was obtained from a newspaper clipping.

## NEWS ITEMS

Dr. Lewis M. Gaines, 65 Forrest Avenue, Atlanta, has resigned as Associate Professor of Neurology and Psychiatry at Emory University School of Medicine, so as to devote his entire time to Internal Medicine and Neurology.

We learned with regret that Dr. M. H. Stuart had removed from Moultrie to St. Petersburg, Florida. Dr. Stuart had made Moultrie his home for nearly fifteen years and had been Secretary-Treasurer of the Colquitt County Medical Society for years, always being among the first to send in his report. We will miss Dr. Stuart and wish him even greater success in his new location.

Dr. A. C. Primrose, a new member of the Sumter County Medical Society, is now associated with Drs. Herschel Smith and E. B. Anderson, of Americus. He will continue his general practice as well as the radium and x-ray work. Dr. Primrose, before moving to Americus last year, was connected with Dr. Howard A. Kelley, of the Kelley Hospital, Baltimore.

Dr. I. G. Armistead has removed from Waycross to Townsend. The members of Ware County are sorry that Dr. Armistead's removal will cause them to have to give him up to Tri County (Liberty, Long and McIntosh Counties) Medical Society.

Dr. Lewis M. Hawkins, formerly having practiced in Americus, is now located in Blackshear. He is being welcomed as a new member of the Ware County Medical Society.

Dr. Herschel Smith has returned to Americus after attending the clinics at the Mayo Hospital, Rochester, Minn.

Dr. D. A. Bagley announces his removal from Austell to Atlanta. He has opened offices at 790 Marietta Street and has bought a home on Bank Head Avenue, Grove's Park.

In a letter from Dr. W. A. Walker, of Cairo, he stated that "Some one has recently stolen a skull from my office. The skull was cut and dressed by Tramond, of Paris, and has that name on it. This skull will be offered for sale to some of the Georgia doctors." Does anyone know of its whereabouts? If so, Dr. Walker would appreciate his communicating with him.

Dr. J. C. Pate left the latter part of July to practice in Tampa, Florida. He was formerly of Macon and a member of the Bibb County Medical Society.

Dr. Newdigate M. Owensby has removed his offices from the Peters Building, Atlanta, to Suite 1012-13 Atlanta National Bank Building, Atlanta. Practice limited to Nervous and Mental Diseases.

Dr. G. Lombard Kelly has opened offices in the Lamar Building, Augusta. Dr. Kelly has lived in Augusta all his life and has taught in the Department of Anatomy in the University of Georgia Medical Department, Augusta, since 1918. At the present Dr. Kelly is doing general practice, but intends later to limit his practice to gynecology and obstetrics.

Dr. Milliard E. Winchester, Thomas County Health Officer, has been signally honored with the offer of a special course at Johns Hopkins by the International Health Board. Dr. Winchester was among one-hundred men selected from all over the world to take this course. He expects to leave the first of October to be gone about twelve months.

Dr. Roger W. Dickson announces the opening of his office at 23 East Kimball Street, Atlanta. Practice limited to Diseases of Infants and Children.

Drs. W. R. McCall, H. H. Hammett and W. H. Clark, all of LaGrange, gave talks at the meeting and barbecue of the Troup County Medical Society, at Hogansville, July 28, 1925.

Dr. J. D. Applewhite is to be congratulated upon his success as Clarke County Health Officer. Four years ago, when Dr. Applewhite first came into office, there were 117 cases of typhoid fever with thirteen deaths in his county for that year. So far he has reduced the number of cases to four for this year without any deaths.

Interesting cases were presented to the members present at the monthly meeting of the Richmond County Medical Society by Drs. H. P. Harrell and Irvine Phinzy, Augusta. Dr. W. A. Mulherin, Augusta, read an instructive paper on "Summer Diarrheas of Children," which was discussed by Dr. F. X. Mulherin, Augusta. "A New Physical Sign in Acute Mastoiditis," was the subject of Dr. John R. Lewis' paper. This was discussed by Drs. C. I. Bryans and T. E. Oertel, Augusta.

The members of the Association will be interested to learn that work on the marble statue of Dr. Crawford W. Long has been started. The statue is to be unveiled in the Hall of Fame, Washington, D. C., about Christmas. At the time the Journal goes to press \$9,683.70 has been raised for this fund, leaving only \$816.30 to be obtained.

Dr. John P. Kennedy has been re-elected Health Officer of Atlanta for the next two years. To show their appreciation of Dr. Kennedy's twenty-five years of service, a large delegation from the Fulton County Medical Society, with Dr. Frank Eskridge as spokesman, appeared before the committee and endorsed Dr. Kennedy's re-election.

Dr. Victor H. Bassett, Savannah Health Officer, addressed the employees of the Standard Oil Company recently on the prevention of malaria and typhoid fever.

Dr. E. Denegre Martin, Dean of the Tulane Graduate School of Medicine, informed us that the School has been re-organized and is in a better position than ever to serve physicians.

The Inter-State Post Graduate Assembly will be held at St. Paul, Minnesota, October 12-17, 1925. Headquarters will be at the St. Paul Hotel.

Broadoaks Sanatorium, Morganton, North Carolina, announces the association of Dr. E. H. E. Taylor with the Institution as Assistant Resident Physician. The completion of two new buildings afford ample facilities for the treatment of all nervous and mental diseases.

### PHYSIOTHERAPEUTIC CONVENTION

Physicians are invited to attend the Fourth Annual Physiotherapeutic Convention to be held at the Drake Hotel, Chicago, October 12 to 16, 1925. Papers will be read and discussed by leading physicians of National and International reputation in this field. For particulars see page program in this issue. Demonstrations and exhibits of the latest apparatus and methods employed in physiotherapy will be given. Physicians who are in good standing in their State Medical Association and can give evidence of that fact are invited. Reservations may be made and programs obtained by addressing the Educational Department of H. G. Fischer & Company, 2335 Wabansia Ave., Chicago, Ill.

### THE TREATMENT OF SYPHILIS.

A working monograph on the treatment of syphilis has been prepared for the medical profession by the Dermatological Research Laboratories which will be sent with the compliments of the publishers to any physician requesting a copy. This booklet discusses the following in separate chapters:

Introduction: Syphilis Today, Arsphenamine vs. Neoarsphenamine, Sulpharsphenamine, Bismuth in Syphilis, Mixed Treatment.

Methods of Treatment: The Primary Stage, The Secondary Stage, The Tertiary Stage, Neurosyphilis.

Intraspinal Injections, Technic of Preparation: Arsphenamine, Neoarsphenamine, Sulpharsphenamine, Bismuth; Possible Reactions; Sodium Thiosulphate.

References: Requests for this monograph should be addressed either to The Abbott Laboratories, Chicago, or the Dermatological Research Laboratories, Philadelphia.

### MARRIAGES.

Dr. J. Raymond Graves and Mrs. Mary Avery Jones were married at Mrs. Graves' summer home at White Bluff, near Savannah, on Saturday, August 8, 1925, at seven o'clock. Dr. Graves is a member of the Chatham County Medical Society.

Dr. Robert Louis Kennedy, of Metter, and Miss Mary Mathis, of Sandersville, were married Wednesday, August 12, 1925, at the First Baptist Church in Sandersville. Dr. Kennedy is a new member of the Bulloch-Candler Counties Society.

### OBITUARY.

Dr. Paul R. Chambliss, of Gray, aged 38, died at Hot Springs, Arkansas, August 3, 1925, of carcinoma of the liver. He was Secretary of the Jones County Medical Society, a prominent Mason and a member of the Methodist Church. He is survived by his wife and three sons, Stanley, Oscar and Paul, Jr. Interment was in the family cemetery at Gray.

J. H. R.

Dr. W. P. Ponder died at his home in Forsyth, July 26, 1925, at the age of 75. He had been in declining health for two or three years. For several years he was the local surgeon for the Central of Georgia Railway. Dr. Ponder was an honorary member of the Monroe County Medical Society.

Dr. J. P. Norris, after a long illness, died at his home in Columbus, July 21, 1925. Dr. Norris was a native of Lee County, Alabama, but had practiced in Columbus for about forty years. He was a member of the Muscogee County Medical Society.



# Proceedings of The Seventy-Sixth Annual Meeting of Medical Association of Georgia

## Atlanta, May 13, 14 and 15, 1925

### Report of the Committee on Health and Public Instruction

(Continued from August issue, page 356)

5. A copy of the resolution, adopted by your body last year, requesting all associations, who are doing health work to secure the endorsement of the municipal or county health authorities and to get the participation of the county medical societies, was sent to all known associations doing such work. It is gratifying to your committee to report that in all answers received they gave their assurance of being in sympathy with the spirit of the resolution and promised their co-operation.

6. In the last bulletin of the A. M. A. there appeared on page 111 a picture of the new copyrighted "Auto Emblem" which can only be secured by members in good standing of the county and state associations. Your committee recommends that you endorse this emblem and that the editor of our journal make a special appeal to our members to secure this emblem.

In conclusion your committee petitions this body and the councillors to appropriate \$500.00 for the promotion of health and public instruction.

Respectfully,

H. B. NEAGLE,  
J. A. THRASH,  
THEO. TOEPEL,  
Chairman.

Dr. Toepel: I move the adoption of this report.

Dr. Thrash: I amend the motion, that the report be adopted with the portion referring to a man being invited to give the talk referred to the Committee on Public Instruction, and the portion referring to the appropriation of funds referred to the Council. I second the motion, with these changes.

Dr. Toepel accepted the amendment.

Dr. Clark: I wish to make the suggestion that the examinations be made by the members of the County Society rather than by the Medical Association of Georgia.

Dr. Toepel: Our Committee makes the same recommendation that Dr. Clark has proposed.

Dr. Toepel's motion was then put to a vote and unanimously carried.

### REPORT OF CANCER COMMISSION

Mr. President and Gentlemen of the House of Delegates of the Medical Association of Georgia:

In appearing before you for the 8th time since the creation of your Cancer Commission, I want to give you a brief outline of the review given our report to the American Society for the Control of Cancer in the official publication of the Society. "Campaign Notes," Col. VII, No. 4, April, 1925. It is very flattering and I feel grateful that I was given the support of the State Medical Association, the co-operation of the profession, the people and the press of the State which made it possible for me to make the report I sent the National Society. The review is entitled, "What a State Chairman Can Do," and is in part as follows:

"An excellent example of what a state chairman of the American Society for the Control of Cancer can do to organize and energize an active campaign of several weeks duration has been afforded by the report of Dr. J. L. Campbell, State Chairman for Georgia and Chairman of the Cancer Commission of the Medical Association of Georgia.

Much time was spent in selecting active men to head the campaign in the various sections of the state, for a district chairman was selected for the twelve congressional districts, a county chairman for each of the one hundred and sixty-one counties and a local chairman for all the larger cities.

Early in the year a circular letter was sent to the district county and local chairmen, together with a description of a scheme for the organization of the committee work. It requested the district chairmen to select a central committee for their district, and each county and local chairman to select and organize a committee with the following personnel:

The President and Secretary of the County Medical Society, a member of the county Board of Health, or county health officer,

a dentist, a nurse and the editor of the county or local newspaper.

The State Medical Association contributed \$150.00 to the campaign and instructed the Commission to work with the American Society for the Control of Cancer helping to distribute their literature, etc., so that every opportunity to reach the public might be used to the best advantage.

A series of articles were prepared by the Commission and published by the Atlanta Sunday Journal, viz: 'A Definition of Cancer,' 'Cancer of the Mouth and Lip,' 'Cancer of the Breast,' and 'Cancer of the Stomach and Allied Organs.' These articles contained about eight hundred words each, and were pointed, popular and instructive. They were used by the Journal in a prominent place, having been run in serial form for four weeks.

Later in the year, articles were prepared on 'The Campaign for the Control of Cancer in Georgia,' and 'The Coming Cancer Campaign.' They were also published by the Sunday Journal.

Then letters were sent to the district chairmen, telling them when the campaign would start and giving final details of the work. Parts of these letters were so progressive as to warrant quotation here.

First—'We want a live committee in every county in the state. You as district chairman, will be expected to instruct the members in the basic principles of the work necessary for public education.'

Second—'We want every newspaper in the state to carry an article on cancer control in every issue during the four weeks of the campaign.'

Third—'We want every minister in the state to say something about cancer, either in the Sunday morning or evening service or at the mid-week meeting. If the minister does not care to make the talk, we hope you will do it or appoint someone to do it.'

Fourth—'We want the subject discussed at the Women's Clubs, the Parent-Teachers' Association, and every other club meeting that may be held in the county during the campaign.'

Fourth—'We want the subject discussed society to devote one meeting to the study of

cancer. If this cannot be arranged during the campaign, have it done as soon thereafter as possible.'

The foregoing letter was followed by a letter to the county chairmen which reads:

'I am enclosing four articles for your county paper. They are marked Warning Nos. 1, 2, 3 and 4. Please have No. 1 inserted in the issue immediately following January 15, and one each week thereafter for four weeks. This will bring the subject of cancer control to the best people in your county, for nearly everyone takes the county paper.

I trust that you will put on an active campaign in your county. Dr. Thrash, chairman for Fulton County, has already organized a very active committee and is preparing to give the cancer message to thousands of people in and around Atlanta.'

A letter was then sent to the editor of all the weekly papers in the state, informing them that the American Society for the Control of Cancer was conducting a campaign for the welfare of the people of Georgia. Enclosed were the four articles which it was hoped the papers would print—one each week. The letter stated that the American Society for the Control of Cancer was a philanthropic organization, and that it did not advocate any method of treatment or the patronage of any institution or doctor. Also, that it sought only to teach the people the early symptoms of a disease by which Georgia was annually losing two thousand of her best citizens.

The letter concluded by saying that a few words from the editor might save the life of his best friend, and suggested that if there was any doubt in his mind concerning the use of his paper to advance the cancer campaign, it might be well for him to see Dr. Blank, who was chairman of the society in the editor's county. The editor was assured that the co-operation of the newspapers would be greatly appreciated by the people of the whole state.

The articles were brief, containing popular statements concerning cancer control as that problem related to the individual reader. They dealt with common misconceptions regarding the nature and causes of

cancer and sought to put correct information in the place of the erroneous ideas which frequently were held. They described the early symptoms of cancer and how people should proceed in order to have this disease detected and treated properly while there was still time to make a cure possible. The warnings, which were full of homely expressions and popular phrases, were admirably combined with sound sense and scientific doctrine.

The two church papers, The Christian Index, Baptist, with about 25,000 circulation; and the Wesleyan Christian Advocate, Methodist, with 15,000 circulation, both published in Atlanta, carried the warnings and leading editorials on the subject.

The district, county and local chairmen held many meetings. The women's clubs, civic organizations, religious congregations and various societies gave active aid. It has been estimated that at least two million people in Georgia learned something useful about cancer during the four weeks that the campaign lasted.

When the campaign was over the chairman wrote a letter thanking those who had helped to make the campaign a success and said, 'It is impossible for me to commend too highly the excellent work done by the doctors of Georgia and the hearty co-operation given us by the press, churches and other organizations of the state.'

Those who are familiar with the many difficulties attached to the organization of a state for the purpose of a month's cancer campaign can realize how much energy needs to be put in to movement of this kind to make it really effective, and will agree with us that Georgia should be put upon the honor roll of the American Society for the Control of Cancer."

I have recently furnished the Christian Index with an editorial entitled, "Cancer One of the Outstanding Captains of Death." It was published and I was assured that the Index was always ready to help in any health campaign.

Two months ago I wrote an editorial for our State Medical Association Journal reviewing the annual reports of the Pa. State Medical Association's Cancer Commission. The report is an excellent review of the con-

dition in that state and we hope to be able to give such a review in the near future.

This week the Journal of Labor and Wesleyan Christian Advocate will carry an article on "Preventive Medicine" prepared by your chairman. It has some pointed facts about cancer control.

A few weeks ago I sent out 1,600 questionnaires to members of the Association, up to date I have received 240 replies—of course many duplications must have occurred—1,798 cases were reported in white people and 287 in negroes. (Many of the answers did not state the race or sex of the patient). This ratio is rather different from statistics in the Bureau of Vital Statistics, but I suppose those answering are men who have mostly white practice. In answer to question 8 about 60% thought the campaign had been helpful, 30% did not express an opinion and 10% were doubtful.

Respectfully,

J. L. CAMPBELL, M.D.,

May, 1925.

Chairman, Atlanta, Ga.

Dr. Clark: Mr. President, I move that the House of Delegates express their deep appreciation of Dr. H. H. McGee as a member of this body, and that the Secretary be instructed to extend to his family our deep regret at his death.

Motion seconded and unanimously carried.

Dr. Palmer: Mr. President, I move that we adjourn until 8 o'clock tomorrow morning.

Motion seconded and the House of Delegates adjourned at 10:20 P. M.

### WEDNESDAY, MAY, 13, 1925 SECOND MEETING

The House of Delegates was called to order at 8:10 A. M. by Vice-President, Dr. W. A. Mulherin, Augusta.

#### ROLL CALL:

The Secretary requested each member to turn in a card containing his name and the County Society he represented, or other credentials, and the following gentlemen responded:

- Dr. F. B. Blackmar, Muscogee County.
- Dr. Warren A. Coleman, Ocmulgee County.
- Dr. T. H. Clark, Coffee County.
- Dr. John W. Daniel, Savannah, Ex-President.
- Dr. J. G. Dean, Terrell County.
- Dr. H. L. Erwin, Whitfield County.
- Dr. Howard T. Exley, Chatham County.



Dr. R. C. Franklin, Emanuel County.  
 Dr. Ralph Freeman, Jackson County.  
 Dr. J. L. Garrard, Floyd County.  
 Dr. V. O. Harvard, Crisp County (Councillor 3rd District).  
 Dr. L. F. Lanier, Screven County.  
 Dr. W. C. Lyle, Atlanta (Councillor 5th District).  
 Dr. R. L. Miller, Burke County.  
 Dr. E. C. Thrash, Atlanta, Ex-President.  
 Dr. Cliff Moore, Floyd County.  
 Dr. W. A. Mulherin, Richmond County.  
 Dr. W. E. Person, Fulton County.  
 Dr. J. W. Palmer, Ailey, Ex-President.  
 Dr. W. F. Reavis, Ware County.  
 Dr. E. H. Richardson, Polk County.  
 Dr. O. W. Roberts, (Councillor 4th Dist.).  
 Dr. A. F. White, Butts County.  
 Dr. W. A. Selman, Fulton County.  
 Dr. C. K. Sharp, Tri-County (Councillor 2nd District).  
 Dr. C. W. Strickler, Fulton County.  
 Dr. J. A. Summerlin, Colquitt County.  
 Dr. B. C. Teasley, Hart County.  
 Dr. C. Thompson, Jenkins County.  
 Dr. C. K. Wall, Thomas County.  
 Dr. A. J. Waring, Chatham County.  
 Dr. L. L. Whiddon, Irwin County.

#### MINUTES:

On motion duly seconded and carried the reading of minutes was dispensed with. President Elrod took the Chair.

#### REPORT OF COMMITTEES:

*Committee on National Defense:* Dr. Frank K. Boland, Chairman, submitted the following report:

To the President and House of Delegates of the Medical Association of Georgia:

Gentlemen: In accordance with the resolution introduced at the annual meeting in Augusta, in May, 1924, the President appointed the following committee, known as the Committee on National Defense:

First District: Dr. R. E. Graham, Savannah.

Second District: Dr. H. M. Moore, Thomasville.

Third District: Dr. J. B. Patterson, Cuthbert.

Fourth District: Dr. W. F. Jenkins, Columbus.

Fifth District: Dr. F. K. Boland, Atlanta.

Sixth District: Dr. L. M. Gable, Griffin.

Seventh District: Dr. C. V. Wood, Cedar-town.

Eighth District: Dr. E. F. Griffith, Eatonton.

Ninth District: Dr. John K. Burns, Gainesville.

Tenth District: Dr. F. X. Mulherin, Augusta

Eleventh District: Dr. G. T. Crozier, Valdosta.

Twelfth District: Dr. Ovid H. Cheek, Dublin.

The purpose of this Committee is to arouse interest among the members of the Association in the Medical Reserve Corps of the United States Army, and to increase membership in the Reserve Corps.

Efforts have been made urging the members of the Committee to speak in favor of the Medical Reserve Corps at every opportunity, and to persuade members of the medical profession to accept commissions. Through the work of Dr. Rufus E. Graham, of Savannah, five members have been added to the Reserve Corps and four others are in the process of being accepted. Dr. H. M. Moore, of Thomasville, reports that two members in his district have been added to the Reserve Corps. In the Fifth District more than a score have accepted commissions since the Committee was appointed. The Committee has not been in office very long, otherwise more results would have been accomplished.

The Fourth Army Corps Headquarters, through Col. A. E. Williams and other officers of the regular Army, and Dr. R. R. Daly, of the Reserves, is lending valuable aid in encouraging enlistments and in organizing classes for military instruction to medical men. Opportunities also are given for correspondence courses in medical corps knowledge, and for training in camps.

The Committee feels that this is important work and trusts that such a committee will be continued in office. The importance of the Medical Officers Reserve Corps cannot be overestimated. Other States are rapidly filling out the quota of medical officers assigned to them. According to the Army table there should be at least 500 medical officers from Georgia in the Reserve Corps. So far the number does not exceed 150.

Respectfully submitted,

COMMITTEE ON NAT'L DEFENSE,

Frank K. Boland, Chairman.

Upon motion duly seconded and carried the report was adopted as read.

Dr. Boland: Mr. President, if I may trespass for a moment while I am on my feet I would like to make a brief announcement. You will all recall that for several years we have had a committee on a monument to Dr. Crawford W. Long. This year the President did not appoint such a committee, inasmuch as the Legislature decided it could not appropriate any money for such a monument, as it was to be erected outside the State of Georgia. The committee was abolished. As you know, there has been another committee work-

ing to raise funds for this purpose, known as the Crawford W. Long Memorial Association, and I am pleased to report great success. A few weeks ago I had the thrill of walking into an artist's studio in New York City and gazing upon a seven and a half foot model of a statue of Dr. Crawford W. Long. It has been approved by the daughters of Dr. Long, and it was a great pleasure to me to be permitted to gaze upon this long-sought statue. It may be a shock for some of you to look upon Long as a young man of twenty-six, but the statue has been made of the man as he was when he made his great discovery. We hope to have the statue made in marble and placed ready to be unveiled by the end of this year. We need only \$900.00 more, and if any of you can help us to raise this amount we certainly will appreciate it. (Applause.)

Dr. J. W. Palmer presented the following report:

#### REPORT OF A. M. A. DELEGATES FOR 1924

Allen H. Bunce, M.D., Atlanta, Ga.

J. W. Palmer, M.D., Ailey, Ga.

The 1924 Chicago Session of the American Medical Association was the most successful and largest attended of any in its history. The Scientific Sessions were held at the Municipal Pier and the House of Delegates convened in the Assembly Hall of the American Medical Association Building. This was very convenient as the delegates were served with luncheon on the same floor by the A. M. A. each day we met, which gave us the chance of going through and thoroughly inspecting the building, which your delegates did. This is a magnificent building and is an honor and a credit to the profession of the United States and one of which we have a right to be proud.

The House of Delegates convened Monday, Tuesday, Wednesday and Thursday. Your delegates answered every roll call and attended every meeting regardless of the fact that it was strenuous work.

The A. M. A. is composed of 54 independent medical organizations with membership of 90,056—1,537 more than 1923. The assets of the Association are around \$1,500,000 besides the net income from the Journal and dues for 1924, which were \$301,000, making \$40,000 more than 1923.

The report of the Medical Association of Georgia at the Chicago meeting showed 93 organized counties, twelve less than at the San Francisco meeting; and 1,716 members, which is 141 more than the previous year.

It is impractical to incorporate in this report all the things that took place in the House of Delegates which was published in the A. M. A. Journal under the heading of the Proceedings of the House of Delegates. We are just reporting on the things we think of the most interest to the members of the Medical Association of Georgia.

We would like first to call your attention to two things that President Posey said in his Presidential Address: First that the trained nurse for ordinary service has become inaccessible, except to the rich and for institutional and community employment. I accept at the highest value the present good type of trained nurses. There is need for them, but there is much greater need for a very large number of trained nurses who will perform the simple duties of attendants for the sick. That is the great function of the trained nurse. The ideals of the nursing craft are all away from that point of view. Second, he recommended one thing that has created much comment, "that the educational standard for graduating doctors were too high and that it was responsible for so few rural district doctors and should be lowered." Since then this question has provoked a great deal of discussion pro and con in the medical journals and is still being discussed. We are already feeling the bad effects, for instance, Tennessee has passed a law lowering the standard of the medical practice act to the extent that it eliminates reciprocity with Georgia and other States. Some of those in the discussion suggested that in the pre-medical years add Bacteriology, Physiology and Osteology in place of Physics, Biology and English and then shorten the medical course to three years.

#### Fee Splitting

The Judicial Council having received reports and open statements that the practice of fee splitting prevails in many places and has been on the increase for the last two years and especially since the last meeting of the House of Delegates, recommended that the House of Delegates go on record as condemning such pernicious practice wherever it may be found and urge component societies and constituent associations to purge their membership of any who wilfully refuse or desist from such practice, because the continuance of which can only bring dishonor and reproach upon the medical profession. The Judicial Council suggest that, when a county society is found to enroll so many fee splitting, or otherwise unethical members, as to render it impossible for that society to enforce the ethical standards of the medical profession, in accordance with the laws of our



medical organizations, it then becomes the duty of the State Councillor, whose district embraces such society, to bring the situation before his State Board of Councillors and have the charter of such recalcitrant society annulled and in its place to have reissued a new county society charter, in the name of well-known ethical physicians of such county, in order that a society with ethical standards may be organized and maintained.

### Periodic Health Examinations

The Judicial Council went into a session as a committee of the whole to consider "shall the medical profession vend its products directly to the consumer or shall it sell them to a middle man or third party, or stock companies?" In this session the following facts were brought out: that the physician's work is bought at one price and sold to the consumer by a middleman at a higher price for the purpose of commercialization and speculation. The A. M. A. has gone on record through the House of Delegates favoring periodic health examinations. Since then a number of commercial organizations have entered the field and, as middlemen, or jobbers, are offering to furnish periodic medical examinations to the public generally for a stated sum per annum and to send reports of the findings at the examination to the examined; and some of these organizations are giving advice to the examined as to what they should do for the conditions found. These examinations, of course, can be made only by physicians; hence these companies are signing up contracts with physicians throughout the country to make examinations of all persons sent to them by the particular company holding the contract, and to forward the reports directly to the company. One of the institutions claims to have 8,000 physicians on its list of examiners. The company pays the physicians only \$2.50 for the examination and sells the examinations for \$5.00. That the subject is too extensive to go into, but we believe that enough has been said to show the importance of the subject, and feel that it is incumbent on this body to devise ways and means of setting the public aright on the subject of periodic health examinations, and to convince the people that the proper person to make such examinations and to give advice relative thereto is the family physician, aided, when necessary, by local specialists.

The following resolution was then passed:

Resolved, That the Judicial Council be instructed to carry on an educational campaign in conjunction with the constituent State Associations and to co-operate with other Councils and Bureaus of the American Medical Association in the promotion of periodic health examinations by family physicians.

### Reapportionment

Report of Committee on Reapportionment of House of Delegates were as follows: 950 or fraction thereof was used as the basic number of members in each State Association in determining the apportionment of delegates for each State; on this basis of calculation 128 delegates were apportioned among the constituent State Associations, this making the total voting membership of the House 146 instead of 149. The constitution fixes 150 as maximum. At this meeting there was introduced an amendment to the constitution to be acted upon at the Atlantic City meeting to increase the number of House of Delegates from 150 to 175 and again reapportion at the 1925 meeting in Atlantic City and every three years thereafter. Your delegates did not approve of such an amendment on the grounds to increase the number of voting members will be to make the size of the House unwieldy. But instead let the Scientific Section Delegates be eliminated and those fifteen delegates reapportioned amongst the States and save increasing the membership for a larger apportionment, besides these scientific section delegates are usually always from the big cities of the big States which gives them too much power in the House of Delegates, a few States having the control of the House.

We as members of the Medical Association of Georgia should increase our efforts to have a larger membership in our Association out of the 3,274 physicians in Georgia; because if our membership at the Chicago meeting had been 185 members more we would have been apportioned three delegates instead of two.

### Legal Medicine and Legislation

Dr. W. C. Woodard called a conference of representatives of constituent State Associations to consider methods for making more effective the work of legal medicine and legislation which was held Wednesday afternoon of the eleventh. Members of the House of Delegates were invited to attend. And each State's representative was called on for five minutes' talk. We attended the Conference. At this Conference all the legislative matters, both State and National, were considered. An effective, uniform, Model Medical Practice Act was recommended to be drafted for adoption at the Atlantic City meeting embodying the following five cardinal points:

1st. That all persons, classes, sects or cults, who pretend to recognize and treat human disease, shall stand equal before the law.

2nd. That one fundamental educational standard be required of all, who pretend to recognize and treat human disease, all should



submit to the same license requirements.

3rd. That one Board pass on the fundamental and professional qualifications of all persons seeking a license to permit them to offer their services to the public, as one skilled in the recognition and treatment of human disease.

4th. That this law will prohibit any person engaging in practice, under any name whatsoever, which has for its purpose the recognition and treatment of human disease, until these principles have been complied with.

5th. That nothing shall be written into the law which could in any way be construed as interfering with any method of treatment which any person who had complied with these principles might wish to employ.

### Recommendations

We recommend that the Board of Trustees continue the efforts already begun to procure for physicians the right to deduct traveling expenses and the expenses of post graduate study in the computation of their federal income taxes.

We recommend continued and careful study of the proposed plan for the introduction of medical defense of malpractice suits with a view to determining what assistance can best be afforded by the central bureau to the several State Associations maintaining or planning for medical defense service.

### A Model Constitution

A Constitution and By-Law Committee was appointed. This committee is now collecting the Constitution and By-Laws from the various State Associations with all other available information and are preparing and will present before the House of Delegates at the Atlantic City session for their adoption a model constitution for the constituent State and County Societies to be taken up later by the State Association at their respective meetings for approval, adoption, amendment or rejection as they see fit.

### Amendments to the Constitution

There were several proposed amendments to the Constitution to be acted on at the coming Atlantic City meeting; however, there is only one of major importance, excepting the apportionment measure already mentioned. This amendment is as follows: At some time between the first and fourth day of the annual session of the House of Delegates, the Chairman and the Secretaries of the various sections of the Scientific Assembly and the members of the Council on Scientific Assembly shall meet at the call of the Chairman of the Council on Scientific Assembly and shall prepare and present to the House of Delegates at their meeting on the fourth day of the annual session, three nominees for the

office of President-Elect, and two nominees for the office of Vice-President, and the nominees so presented shall be the only ones eligible for the election.

This is one of the most undemocratic, autocratic steps that has ever been attempted. The House of Delegates is already powerless enough and more or less perfunctory as it is, and if a few measures like this should pass, it would be useless for you to send your delegates. However, we are glad to report the House of Delegates took less dictation at the Chicago meeting than at the San Francisco meeting. For instance, this was the first time in the history of the A. M. A. that the House refused to elect a new member of the Board of Trustees whose name was recommended by the Board of Trustees, but instead nominated and elected an independent member, besides the power of the Board of Trustees have been curtailed by making them non-eligible to a second term.

One of the impressive things in the Chicago meeting was the passing of some of the old landmarks. Dr. Simmons, for twenty-five years Editor and General Manager of the A. M. A. Journal, resigned and retired. The Association elected him Emeritus Editor and General Manager, allowing him a salary or pension of \$5,000 per annum. Dr. Olin West, one of the most elegant fellows you ever met, was elected to take his place. Dr. Frank Billings, who has been Chairman of the Board of Trustees for many years, and who has done so much for the success of the Association, resigned and retired; hence two of the most important figures in the history of the A. M. A. have stepped down and out and left the running of the A. M. A. to younger men.

Upon motion duly seconded and carried the report was adopted as read.

The President announced that he had appointed Dr. R. L. Miller, Waynesboro, a delegate for Burke County.

### UNFINISHED BUSINESS:

*Amendment to Constitution:* Offered by Dr. E. C. Thrash at the 1924 meeting in Augusta.

Dr. Thrash: This amendment needs no special introduction at this time, as it was brought up at the last meeting. The Secretary can just read the amendment, if he will.

The Secretary: The amendment offered was as follows: Article IX of the Constitution, Section 3, line 3, after the word "nomination," insert the following: "except the Councillors, who shall be nominated by members of the respective districts at the last district meeting preceding the annual meeting of the State Association, and these nominees shall be voted upon at this annual meeting, provided nominees are present."

Dr. Harvard: I wish to offer an amendment to this for the reason that the District Society is not a component part of the Association. Therefore, have it read that they "be nominated by the House of Delegates, provided they are present."

Dr. Thrash: While the District Societies are not a part of the Association the members of the Society are a part. Instead of accepting Dr. Harvard's amendment I will offer this: that the members in the District meet in executive session as members of the State Association and nominate their Councillor. That would not be a District meeting; they could call a meeting of members of their District as members of the State Association.

Dr. Clark: With Dr. Harvard's permission I would like to change the wording of his amendment and second it. Instead of having it read as at present I would suggest, "except the Councillors who shall be nominated by the House of Delegates, two members from each Councillor District being nominated and acted upon." If Dr. Harvard will accept this I will second the amendment.

Dr. Harvard accepted this suggestion.

Dr. Thrash accepted this suggestion.

Dr. Clark: I am sure it had not occurred to either Dr. Thrash or Dr. Harvard, but the District Society has no part in the Medical Association of Georgia. It is for the purpose of encouraging the good of the medical profession in that district. It is composed of the County Societies in that District, and it would be unwise for this Association to put into the power of a society which is not functioning with it the power of nominating some of the most important representatives of the Association.

Dr. Thrash: Would it not be feasible if they had a District meeting to go into executive session, because they are gathered there at that time, and the members of each respective society can make the nomination. They could organize as members of the Association, separate from the District Society, and make their nominations.

Dr. Clark: The nominations of any deliberative body or organization are controlled by that organization. To illustrate, Georgia is represented in Congress. Certainly Georgia would not empower any members of the Legislature to nominate any officers. The Medical Association of Georgia should be very careful about empowering any society to nominate any of its members. The County Society is represented in the Medical Association of Georgia in the House of Delegates, so let the House of Delegates nominate your officers, if you please. If you follow your rules now

you know how long it takes to vote for officers without nominations. It has been suggested that the House of Delegates nominate two gentlemen. That does not take away the power of nominating from the floor. These names are presented on the last day, and this is carrying out the spirit and letter of the law of the organization. It is facilitating matters and is getting a better representative from each District, for certainly the county societies know better than anyone who are the active men in their locality.

Dr. Thompson: Dr. Thrash's idea is that each District knows who will make it the better Councillor than does the Association at large, and it seems to me that if the delegates from each County should nominate these two men to be voted upon by the Association that this would settle the affair.

Dr. Clark: As I understand it Dr. Thrash accepted this.

Dr. Thrash: I think I can satisfy Dr. Thompson in this matter. The House of Delegates will not oppose at any time any man that your local society nominates. That would be unprecedented. You may have your primaries, your election, down there when your District Society meets and recommend to the delegates from your District that they nominate so and so. You can go on unofficially and pick your man at the District meeting and notify the delegates that this has been done. The name will be presented here and he will be elected. This proposition of Dr. Clark's will not interfere with the local society's electing their man. Just get together at your District meetings, select your man at your primaries there and present his name here. There is not a member of the House of Delegates who would oppose any such man and he will be elected.

Dr. Miller: Since Dr. Thrash explained this as he has had not Dr. Clark better leave out two and say one instead? If they bring in a nominee's name I would suggest that the House of Delegates nominate only one man.

Dr. Clark: That is just a side issue of Dr. Thrash's. It has nothing to do with the State Society. It would be wise for your County societies to give their delegates instructions as to whom they shall nominate. I thought it would be fairer to give two. If they nominate only one man that does not give any choice. I have no objection to one if Dr. Harvard has not.

Dr. Waring: One point: as I understood Dr. Thrash's original idea it was to make the doctors in the different parts of the State a little more interested in the selection of their Councillor. I think many of them are not sufficiently interested. His idea was that they



must select their Councillor. His present idea is that they can. They will not do it—the primary will not meet.

Dr. Harvard: I have no objection to have it read one member instead of two, but I think the idea of having the County societies take an interest in it is a good one.

Dr. Dean: Did Dr. Clark mean that they would not be allowed to get together, say at a District meeting? If not, I think there would be no chance to agree on any one man. Each Society might want a man from their own Society. I think they should have an opportunity to get together and agree on some one man and it seems to me the District meeting would be the time.

Dr. Palmer: It looks to me as if the District meeting would be the best place for this nomination. If each delegate is responsible for his constituent body he has to go back home and say who he voted for, and if they present the name to the House of Delegates that is all that is necessary.

Dr. Clark: Regarding Dr. Dean's question, you know many men are interested in the District Society when they are not interested in the County Society. The real object of the meeting is the social part and the discussion, although they have a few papers. The District Society is really for friendly purposes. Of course, in America, there must always be some politics. If this were put in the District Society that would make more politics, and it might possibly increase the attendance, but would increased attendance be better than the harm that might be done by it? The County Society is supposed to elect the man who will work for the best interests of that County. Of course, each County Society has its preference, and that is wise. The wisdom of letting it come before the House of Delegates lies in the fact that the House of Delegates is the official representative of the Medical Association of Georgia and they are considering the best interests of the Medical Association of Georgia and will impartially thrash out these matters and select the men best suited to represent the different localities. The delegates from District Six or District Two, if they get instructions before they come, if they cannot agree on one man, let them have several. Then the House of Delegates gets the pros and cons after deliberation, and that is what the House of Delegates is. It must get the facts and deliberate on them and then come to a conclusion. After the County societies thrash this out they make their nomination and this goes to the House of Delegates. This makes it much better and brings it where it should be. It offers the fairest means for securing the representatives of the societies.

Dr. Wall: I think we should have this read again before we put it to a vote.

Dr. Clark again read the proposed amendment and Article IX of the Constitution.

Dr. Reavis: As I understand it this does not prohibit another man being nominated from the floor at the annual election.

The President: That is true. You can vote on half a dozen if you want to. If there is no further discussion all in favor of the amendment, as amended to one instead of two nominees, signify in the usual manner.

Amendment adopted, as follows: "Except the Councillors who shall be nominated by the House of Delegates, one member from each Councillor District being nominated, and these nominees voted upon at the regular annual election, provided they are present."

#### NEW BUSINESS:

Dr. Daniel: A very important matter was partly thrashed out last night but not finished, and that was the employment of an attorney to advise us on matters of legislation. I do not wish to use the word "lobbyist." and hope this will be kept within the executive session. As you know, last year we talked a great deal about public health in Georgia. We have a standing committee on such legislation. We have done a great deal of work trying to get an increased appropriation for public health work, without any success so far. You as members have tried the same thing before and know where the impediment comes in—that we have no funds to employ a paid representative to represent us

I wish to move that the House of Delegates go on record as recommending the employment of a counsellor to represent us in the Legislature, and that we request the Councillors to take care of this expense.

In making this motion I do it for two purposes: first, the Georgia Bankers Association are heartily in favor of the appropriation from the State Legislature for health work. They realize that Georgia must take a step in this direction or Georgia will lag behind the other Southern States. Second, the Georgia Manufacturers Association are also in favor. These organizations have signified their willingness to back us in getting an appropriation from the Legislature. We will get a report later in the day as to how much they will back us in order to carry this matter through. The Georgia Manufacturers are in session in this same hotel, and I have talked to some of them about this. They will probably request some of us to appear before them and outline our work and the gentlemen



I have talked to have assured me that they will appropriate a fund to help us carry this on. We are only recommending to the Association the adoption of a plan to employ a counsellor. We are requesting the Council to furnish the funds for this purpose. We want some action which will enable us to get in touch with the two other representative bodies in Georgia.

Motion seconded.

Dr. Clark: I think the gentleman is out of order. Is it not true that this is all embodied in the report of the Committee on Legislation? It seems to me it would be wise to wait for their report. They are to report on Thursday morning and I think we should have their report and consideration in order to act on it. I so move, Mr. President.

Dr. Reavis: I agree with Dr. Clark, and second his motion.

Dr. Daniel: I do not see where this is out of order. This is a business body and we have a right to bring up anything that has been acted on before. I do not know how I can appeal from the Parliamentarian, but I appeal from the floor.

Dr. Clark: I did not give you my opinion as Parliamentarian but as a member of the House of Delegates. As your Parliamentarian I wish to act without offense to anyone. I wish to do the thing as kindly and gentlemanly as I know how, but I do not feel that because you have made me your Parliamentarian it deprives me of my other privileges. As the Parliamentarian I am a member of the House of Delegates; as an Ex-President I am a member of the House of Delegates, and as a member of the House I got up and made the motion.

Dr. Daniel: The gentleman said I was out of order and that is why I brought in the matter of the Parliamentarian.

Dr. Mooney: While it is true that the report was put on the calendar to be acted on tomorrow morning, the Georgia Manufacturers Association is in session today and I do not know whether they will be tomorrow morning. They realize the necessity for health work in Georgia and I think we should get in touch with them today. I think it would be well to appoint a liaison committee, if you please, and let them know what we can do.

The President: The Committee on Public Policy and Legislation have a right to get in touch with the Manufacturers' Association as much as they wish.

Dr. Miller: I think Dr. Daniel's motion is a good thing, and as I see it the reason for acting on it this morning is that it will give us an opportunity to go before these people

and tell them what we have done and that will spur them on. We can write and talk about Georgia and call it the Empire State and all that, but until we get health in Georgia we are not the Empire State. At present we spend about six times as much for coffins in Georgia as we do for health. Those of you who have not backed up against the Legislature of Georgia do not know what you are dealing with. I know. We stayed here for about ten days in regard to the Medical Practice Law we have and then got nowhere because we were dealing with a lot of unscrupulous politicians. I think the motion is a very good one.

The President: If there is no further discussion we will vote on the amendment offered by Dr. Clark.

Upon rising vote the amendment was carried and the matter was referred to the Committee on Public Policy and Legislation.

Dr. Mulherin: I wish to bring up a resolution and say a few words before introducing the resolution. There is a lot of extension work going on and this is being put over in different ways. In some places the men go out and in some places the men come in to the universities. The purpose is to advance medical science. The University of Georgia has put on this extension work. They want to go and exchange ideas. They do this by writing to the secretaries of the various County societies and asking if they may not come out to the society meetings, hold a clinic and exchange ideas. The men at the University realize that if they go out they learn something. They become better teachers, keep up on the various subjects, and can impart better knowledge to the men throughout the United States. We wish to introduce a resolution asking for the stamp of approval of the Medical Association of Georgia. We want you also to realize that it is your State University. The men in Augusta are interested because they are teaching and are located there, but we want your co-operation and to get in better touch with you. The resolution is as follows:

Whereas, the Constitution of the Medical Association of Georgia states that two of its purposes are, "to extend medical knowledge and advance medical science," and "to enlighten and direct public opinion in regard to the great problems of State and medicine, so that the profession shall become capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life," and

Whereas, the Medical Educational Extension work, as carried on by our State University, and other medical colleges in the State,

has as its objective the same identical purpose; therefore,

Be it Resolved, that the Medical Association of Georgia heartily endorses the good work that is being done along this line by the Medical Department of the University of Georgia.

I move its adoption, Mr. President.

Motion seconded.

Dr. Clark: May I ask if any of the work is being done by any of the other medical colleges in the State?

Dr. Mulherin: If they are I wish to endorse it. I think organized medicine should put the stamp of approval on the things that lift and have for their purpose the same things that the Medical Association of Georgia has. If Emory University will come in we will welcome them. There are three branches at present that we are extending, medicine, public health and pediatrics. I would like to see Emory come in, and if Emory starts put the stamp of approval on it.

Dr. Clark: I thought it would be well for the House to act impartially and make it the universities of Georgia.

Dr. Mulherin's motion was put to a vote and the resolution was unanimously adopted.

The President: I want to request all the members of the House to have their nominations for Councillors ready for our meeting tomorrow morning. Is there anything further to come up at this time?

Dr. Harvard: I wish to introduce a resolution, as follows: That a Committee on Public Policy and Legislation be appointed and composed of three members who shall serve for three, two and one year, respectively, and thereafter for three years. I move its adoption.

Motion seconded and carried.

Dr. Lyle: After listening a few minutes ago to Dr. Palmer's report of the Delegates to

the American Medical Association, I realized there was one matter which he did not touch upon. I think some action should be taken upon it by this Association and I wish to offer the following resolution:

Resolved, that the Medical Association of Georgia pledge its aid in an effort to have repealed, or modified, the present law requiring physicians to purchase a narcotic license, the proceeds of such license fees going to the providing of revenue for the revenue department.

I do not think it is necessary to discuss this, but I feel that we should make a protest as physicians against paying a license fee of \$3.00 which goes toward maintaining a department which should be maintained by the Government. I move the adoption of this resolution.

Motion seconded.

The Secretary: We have received a communication from the American Medical Association on this matter and I wish to amend Dr. Lyle's motion to include the following things:

1. The war tax under the Harrison Narcotic Law.

2. The tax on traveling expenses necessary for attendance at meetings of medical societies.

3. The tax on the expense of postgraduate study.

Dr. Lyle accepted the amendment and the motion, as amended, was put to a vote and carried.

The President: If there is nothing further to come before us at this time I will entertain a motion to adjourn.

Upon motion duly seconded and carried the House of Delegates adjourned at 10 A. M. to reconvene at 8:00 A. M. on Thursday.

(To be continued in October issue)

Have You Read What Your Advertisers Have to Offer?

*Do you know the most up-to-date medicine to prescribe for your patients?*

*Do you know how to tempt the convalescent's diet?*

READ THE ADS AND KEEP UP WITH THE TIMES—THE ASSOCIATION GUARANTEES YOU SATISFACTION

# THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL PROFESSION OF GEORGIA

PUBLISHED MONTHLY under direction of the Council

Volume XIV

Atlanta, Ga., October, 1925

No. 10

## Original Articles

### PROBLEMS OF PATHOLOGY OF THE BILIARY TRACT\*

William Howard Lewis, M.D.,  
Rome, Ga.

The early conception of renal pain and one which a large percentage of the profession still retains, was that it is due to the passage of stones. A more thorough knowledge has demonstrated that stones are a minor element while infection to a varying degree with related or unrelated mechanical obstruction is the greatest factor. Furthermore it is a well known fact that the early damage to ureter and kidney pelvis if unrelieved will not infrequently lead to extensive involvement of the kidney.

The mechanism of kidney damage is today well understood and is probably in many ways analagous to processes in the liver and biliary tract. Doubtless one of the greatest handicaps to a proper visualization of the latter problem has been the established expression "gall stone colic" or "gall bladder colic."

This term alone unconsciously centers attention upon the gall bladder, regardless of the great hepatic machine, while on the other hand the expression colic conveys the idea that the pain is directly due to a contraction of the gall bladder which while true in a group cannot be true in all. There is probably no instance of greater gall bladder pressure than in an acute infection but here the pain is not colicky in nature but that of a constant tenderness and ache. Some of the most extreme instances of colic the writer has ever seen occurred after the gall bladder had

been removed and where subsequent operation proved that there was no mechanical obstruction in the biliary tract. And how often have cases of colic come to operation or autopsy with a gall bladder atrophic and shriveled and no concurrent obstruction? We must dissociate our mental processes from these previously accepted relations and think of these problems as involving the liver, biliary ducts, gall bladder and at times the pancreas and duodenum, and in passing reference to the latter may we ask what is pylorospasm in fact?

The sympathetic nerve supply of this entire area responds to an alarm in any portion of its distribution and need not indicate a mechanical process. The so-called cardiac anginas may originate in aortic or coronary changes and we do not at such times conceive a heart muscle in actual spasm.

Much of what follows may be trite but some of these accepted propositions must be reviewed if we are to arrange them in a somewhat different relation or employ them with an altered perspective. The rupture of old habits of thought is one of the most difficult attainments of the human mind.

The liver is a disposal headquarters for the entire body. Various systems of drainage lead to it from the bowel carrying products of digestion, harmful and harmless, which must be altered, adjusted chemically, rendered innocuous, discarded or stored for further service. The blood stream from the body undergoes more or less unknown changes in the liver, various products being removed and undoubtedly biological and chemical poisons being eliminated through it. The reaction to dyes and various inorganic poisons is

\*Read before the Medical Association of Georgia, May 13, 1925.



clearly indicative of this function. In what manner and to what degree these biochemical processes are conducted we know next to nothing. We recognize the end products and also appreciate comparatively gross changes when at operation or autopsy, an abdomen is opened for inspection but how many of its secrets has it given up, how much of the intermediate process are we to know?

All of this leaves out infection to which our attention has been sharply called in recent years and which must be accepted as a dominating influence in disease. Most of the recent discussion relative to infection has been directed toward head foci and brilliant evidence has been submitted. What do we know about the great sewer in the abdomen from which there must be some leakage, all diverted toward the liver filter? What about the chronic infections, male and female, which smoulder for years? Nature's defense may prevent an active onslaught but in the constant struggle what happens to the defenders, the lymphatic and hepatic reserves? Of this, we know nothing and can only surmise its extent and character. That the apparent state of health is so consistent certainly indicates a wonderful efficiency and vigilance upon the part of this system. But here again may not the extra gall bladder problem be the paramount one? Is infection going with uncanny instinct to select only the artery of the gall bladder and so invade its walls or is it going via the entire hepatic circulation to be passed into the bile stream and thus reach that organ? The latter process, logically and experimentally, is the accepted one. Therefore, where is the damage to be confined—only to the gall bladder? Where is it to occur primarily? Only in the gall bladder?

When we consider as an entity all of these chemical and infective agents acting directly or collaborating to produce changes in this system we are forced to the conclusion that we are today dealing more or less with end results and have been largely content to do so. That like the early appendix period, we have been awaiting the development of the "typical case" a specious euphemism for the "advanced case."

Whether this has anything to do with "cectomy" or "ostomy" the writer does not pretend to know. It seems probable that at a certain stage the gall bladder is the focus or remnant of damage or infection and in this happy group its removal largely solves the problem. If it is allowed to persist in this group we may have an extension of trouble. Surgical drainage is a measure to which we resort when nature is exhausted and in no other instance is it recognized as wise to await such a situation. The writer is not referring to the so-called "medical drainage" of the biliary tract which seems rather mythical.

Clinical evidence and records indicate that these patients with this syndrome have more or less definite trouble for years before resorting to surgery. They are usually driven to it when life becomes intolerable. Do we regard any other group of patients in this light? Do we advise awaiting the rupture of an appendix or postpone the treatment of a pyelitis till a pyonephrosis occurs? In this intervening period of years a certain percentage of the group will have attained a liver or pancreatic damage which is irremediable and surgery then in place of attaining a triumph is brought into disrepute. Most cases suggest trouble before thirty and do not have operation till after forty, hence "gall bladder disease" is supposed to be one of later life. It is not. Disregarding the acute attacks a distressing indigestion is a result of this condition and as the liver is a most fundamental part of digestive physiology we not uncommonly see these features continued even after the removal of the gall bladder.

What is to be done? The writer does not presume to know. Much research and clinical work remains. The new investigation with dyes may throw some light but the problem is complex and nature will not reveal these innermost secrets without a struggle. The strenuous efforts to arrive at a more definite knowledge of gall bladder conditions by x-ray contains an element of danger. A gall bladder giving positive x-ray findings usually gives ample clinical evidence and a negative x-ray finding in no way precludes disease or even stones. The risk lies in the fact that there may develop a tendency to

await x-ray evidence and in the meantime pathology progresses. As typhoid fever disappears a great causative agent will be disposed of. If pregnancy were less common or disposed with another troublesome element would be removed. Is obesity an incident, the dietary indiscretion placing an undue load on the liver as well as adding to the girth? All appendix, pelvic and bowel infection should be promptly and thoroughly cleared up. Alcohol although itself still popular does not seem to be regarded as such a liver enemy as formerly and may not the old cirrhoses be merely a phase of the same problem? How often did the pathologist of yesterday discourse on the cirrhotic liver and casually dismiss a gall bladder bearing the scars of many a battle? And how often do the moderns direct their attack upon the gall bladder and dismiss the liver with a cursory comment? Hygiene, food proper in quality and amount, exercise and bowel care are natural processes observed in their neglect and must be powerful factors for good or ill.

The crux of surgical intervention remains. The writer believes that like fire and electricity, properly served, it is of inestimable benefit but can not be applied indiscriminately. It seems reasonable that a patient in whom infection or trauma of the liver or gall bladder is positively present and persistent for a definite time and in whom ordinary measures do not obtain relief should be a worthy subject for surgery. He will probably require it sooner or later and later he will be older, possibly fatter and surely there will be added pathology which may or may not then respond. Here we tread upon dangerous ground. Every subcostal ache, digestive distress and "liver complaint" is not due to the above pathology and it would be disastrous for surgery to be resorted to indiscriminately in this field. The diagnosis must be quite certain, not conjectured. It is to be regretted that too much gall bladder surgery is still being handled on this latter basis.

In spite of all the surgery of the upper right abdomen the final solution has not as yet been arrived at, removal or drainage of the gall bladder cannot be determined by a table of logarithms and it is a field demanding the broadest experience and keenest judg-

ment. The writer believes that much earlier operation in definitely established cases will afford the patient a larger measure of relief, the surgeon a greater degree of success and will prevent a number of complications which now account for operative and post operative perplexities and which eventually subtract years from the patients life time.

#### DISCUSSION ON PAPER OF DR. W. H. LEWIS.

DR. GEORGE McC. NILES, Atlanta, Ga.: I have listened to Dr. Lewis very attentively indeed. The subject of his paper and one allusion he made is my excuse for my discussion.

In regard to the non-surgical drainage of the gall-bladder, I have paid great attention to it, I have worked with unremitting zeal to try to get something out of it, I have followed it for five years, I have used it 4,200 times, and the further I go the more I can see. Of the patients who come to my office 18.5 per cent have been through the surgical mill, and a little over 1 per cent of that group have had the gall-bladder removed. They do not come for fun because my office is not run as a philanthropic institution. They know that when they come there they come for business and that it will cost them something. Yet I have this advantage over the surgeon, except for gall-stones and empyema, which are admittedly surgical procedures, he has just one shot in his rifle, while with the non-surgical drainage we have an unlimited number of shots. I have patients who come back every two or three months. I do not put them to bed. It is only a matter of a few hours and they evidently like it or they would not come back for it. There is about 5 per cent in which we do not get any results, but I have seen a report from Johns Hopkins in which they claim there is no relief in 6 per cent of these cases from surgery. I have one patient eighty-two years old who comes in three times a year. In some cases the good results last longer than in others. I had one patient come in for whom surgical drainage relieved her for only five months. Sometimes my non-surgical drainage holds them for five months, sometimes less and sometimes more. Dr. Lewis does not approve of this procedure and I wish it were otherwise for a man with his bright mind and broad influence on our side would help us to put this over.

In cleaning up the gall-bladder I am reminded of the twelve tasks of Hercules. As many of you know, one of them was to



clean the Augean stable, which contained 3,000 oxen and had not been cleaned for thirty years, but Hercules turned in two rivers and cleaned those stables in one day. Gentlemen, we have an opportunity in this way to get these patients cleaned up and get them well, and if we do not relieve them we have not hurt them; if we do relieve them the patients will rise up and call us blessed.

DR. W. R. DANCY, Savannah, Ga.: If I recall correctly, Dr. Lewis said that he allowed the natural forces to take their course and aided them as much as possible before operative procedure. I feel as he does, that there are some cases that must go to the surgeon, but I think many cases that he would send to the surgeon should not go there. I have been a doubter for years relative to the non-surgical drainage of the gall-bladder. I had to be shown and since being shown I must say that I have obtained some very remarkable results. At first these were a great surprise to me. Now, in this type of selected cases, I always use the non-surgical drainage.

The point that is to be made relative to the non-surgical treatment of the gall-bladder is whether there is drainage of the gall-bladder. Anybody who knows that there is drainage of the gall-bladder cannot help admitting that that is draining the gall-bladder just as we would drain any other infected cavity. Lyons, several years ago, introduced the duodenal tube, received the plain bile, then injected his magnesium sulphate and removed a large amount of bile from the gall-bladder in the cases where there had been typhoid fever which evidently had infected the gall-bladder. The first bile removed from the stomach had no typhoid bacilli, but the bile from the gall-bladder contained a great number of organisms and this was aspirated. I will not go into detail in regard to the other proofs, but I wish to mention the work of several men in different parts of the country who have been working with a new method. These men inject the salts of tetraphenolphthalein. These salts are stored up in the gall-bladder and by getting in the duodenal tube, getting it *in situ*, and then waiting a considerable time the gall-bladder is emptied and the tetraphenolphthalein is evacuated. This has been seen by the fluoroscope and can be demonstrated by the x-ray film. Roentgenograms taken before and after drainage show the emptying of the gall-bladder.

DR. C. W. ROBERTS, Atlanta, Ga.: Like Dr. Niles, I listened with most intense interest to this paper. So far it seems to me that the meeting has resolved itself, with the exception of the very fair way in which Dr. Lewis presented his paper with respect to

surgery, into a debate as to whether sick people should be turned over to surgeons or to medical men. I have always believed that there should not be such a thing as a division between the medical men and the surgeons. The surgeons have made many mistakes for the reason that the embryo schools have turned out many so-called surgeons who had no right to operate, but who thought that because a patient had some pain they should operate, but these mistakes should not interfere with the field of real surgery. I rise, therefore, to speak not as a surgeon but as a physician who has undertaken to study surgery and who applies surgery where the medical man believes it should be applied.

This problem is not new to the surgeon or the internist. We have all realized that we have met our Waterloo many times in dealing with these so-called "liver cases," "gall-bladder cases" or what you like. There is a group of cases in which the infection comes from the appendix, the teeth, the tonsils, or wherever it may originate, the brunt of that pathology, due to some pathology in the cystic duct, the common duct, or what not, due to some anatomic interference with physiological drainage of the gall-bladder, the brunt of that infection falls upon the gall-bladder. In that group the surgeon cures the patients if he relieves the stasis, whether by removing the gall-bladder or draining it. We have found for a long time that if we are not too keen and simply tie up the cystic duct and get out and call that an operation, if we look in the patient's abdomen we will find evidence of the pathology having extended into the liver. Where you find the gray lines, the evidence of scar tissue changes in the liver substance, you will not cure the patient whether you take out the gall-bladder or not, and the honest surgeon will acknowledge that fact.

We do not profess to cure all of our patients, but we believe that by the honest application of the surgical art we will be able to cure some and relieve many.

DR. LOUIS F. LANIER, Rocky Ford, Ga.: I am much pleased with Dr. Lewis' paper on the gall-bladder, and in the interest of the men who have not the opportunity of using the Rehfuß tube, or do not possess one, I wish to call attention to an article which I read not long ago in the Journal of the American Medical Association, which was contributed by some man in the North. He laid a great deal of stress upon small doses of magnesium sulphate by mouth, comparing it with the non-surgical drainage of the gall-bladder. This struck me very forcibly, for the man discussed at length the value of this



method of non-surgical cleansing of the gall-bladder.

DR. W. H. LEWIS, Rome, Ga., (closing): I wish to heartily endorse Dr. Roberts' appeal for a unity of opinion between the medical men and the surgeons. The surgical attitude and medical attitude are too often antagonistic to the prejudice of both. I am neither a surgeon nor an internist. I work too much with surgeons to want to be one, and so with the others. I think the man who sees a number of autopsies and then follows a large group of these cases post-operatively does not have to rely upon his imagination as to the result, but has a better idea of what is due to the failure of surgery and what is due to the failure of medicine. There is no diagnosis so safely sure or surely safe as a medical one.

What I wanted to bring out in the paper is that the failure of surgery in the so-called gall-bladder group is very largely due to the fact that these patients have been held up, not by their doctors perhaps but by their dread of operation, so that when they do come to the surgeon they are asking the surgeon to perform a miracle. They want a new liver, a new pancreas, and when the surgeon cannot supply these he is no good. On the other hand, there is the intrepid surgical attack on the gall-bladder. I have seen patients operated on who have never had any indication of gall-bladder disease. That brings disrepute upon surgery.

There are two sides to the proposition. As to medical drainage, I said I felt that it was inadequate. I did not say that I did not think it accomplishes something, but I meant that in the extensive pathology of the biliary tract I did not see how in the large group of cases it would give the prophylactic results we would like to have.

#### ROENTGEN-RAY TREATMENT OF HYPERTHYROIDISM

A study made by Thomas A. Groover, Arthur C. Christie and Edwin A. Merritt, Washington, D. C., (Journal A. M. A., Nov. 29, 1924), of the results of roentgen-ray treatment of hyperthyroidism in individual cases and by means of the incomplete statistics so far available indicates that this method will probably furnish about the same percentage of permanent cures of exophthalmic goiter as a surgical treatment in the best hands. The roentgen-ray method has the following advantages: (a) There is no mortality resulting from the treatment; (b) patients will submit to this method of treatment at a much earlier stage of the disease than to operation; (c) the method is applicable to inoperable and to post-operative cases. Patients with hyperthyroidism should first receive roentgen-ray treatment, and be operated on only if the disease fails to respond to the treatment. This would not apply to patients with toxic adenoma with mild hyperthyroidism who have no vascular or other diseases which render them inoperable. The operative mortality in this class of cases is very low, and surgery has the great advantage of removing the tumor. Our general impression is that roentgen-ray treatment is not so useful in toxic adenoma as in exophthalmic goiter, but that it may be of great advantage in rendering very toxic cases operable and in the treatment of cases that are inoperable for reasons other than the hyperthyroidism.

#### ALKALOSIS ACIDOSIS\*

##### CASE REPORTS

John W. Daniel, M.D.

Savannah, Ga.

The blood, the liquid tissue of the body, has several important functions: Among which is the carrying of food from the intestines to the tissues; the carrying of oxygen from the lungs to the tissues; the removal of waste matter from the tissues to the lungs, kidneys, skin, and other excretory organs of the body to be eliminated. It also provides for the carrying on of proper metabolic balance by distributing the internal secretions from one organ to others to be utilized, and also plays an important part in body defense against invading organisms.

In this paper, I will consider principally the oxygen carrying power of the blood, and the power of carrying waste matter to the excreting organs.

The blood, being the liquid tissue of the body, bathes all parts of the body, and, under normal conditions, has the ability to accommodate itself to the needs of the parts. It has the ability to maintain an equilibrium between the acid and base radicals, thus retaining neutral state—alkaline to litmus, acid to phenolphthalein. This acid base equilibrium is maintained through the presence of sodium bicarbonate, sodium carbonate, disodic hydrogen phosphate, and the alkali salts of both the corpuscles and plasma proteins. This acid combining power of the blood is of great importance, for it is through this combining power that the blood is able to pick up carbon dioxide from the tissues and carry it to the lungs, there exchanging the  $\text{CO}_2$  for oxygen and carrying it to the tissues.

Hasselbach has shown, in his works, that there is a definite relationship existing in three interdependent variables in the blood—sodium bicarbonate, carbonic acid gas and hydrogen ion. Henderson has shown that the interdependence of these three variables extends to three more variables—free oxygen, oxyhemoglobin and sodium chloride. Observe in the cases to be presented, the relation of the dependent variables. In the blood we also find the first evidence of a failure in

\*Read before the Medical Association of Georgia, May 13, 1925.

function of some organs, the most important being the kidneys and the pancreas.

With these statements as to the importance of a careful study of the blood as an aid to the physician, I will cite, first, three cases showing the aid that a surgeon can derive from a study of the blood chemistry of his patients. In all reports the findings are based on milligrams per 100 c. c. of plasma or blood.

#### Case Reports:

Case 1. Male, colored, age 60 years, laborer: Could not get any history of previous illness, family, etc. Was brought in from country with a strangulated umbilical hernia of two days standing; vomiting incessantly and in a state of collapse. Operated, found gut strangulated but not gangrenous; released gut; sewed up wound. Patient continued to vomit, soon became pulseless and collapsed. Twenty-four hours after operation was asked to see case.

#### Blood Chemistry:

Hydrogen ion	7.6
Carbon dioxide	60 vol. %
Chlorides	375 mg.
Sugar	187 mg.
Nonprotein nitrogen	150 mg.
Creatinine	3.2 mg.

The second chemistry, which was made about an hour before patient's death, gave the following results:

#### Blood Chemistry:

Hydrogen ion	7.5
Carbon dioxide	60 vol. %
Chlorides	360 mg.
Sugar	300 mg.
Nonprotein nitrogen	172 mg.
Creatinine	4.5 mg.

The hydrogen ion remained about the same, chlorides dropped, nonprotein nitrogen and creatinine increased. A second operation was advised but refused. Autopsy showed obstruction of small gut about three feet above caecum.

Case 2. Mrs. T., age 30 years. Two weeks previous had been operated on for pus appendix, drainage. Patient made good recovery and returned home. Three weeks later, while eating dinner, became nauseated and vomited. Physician was called; gave saline cathartics and enema—small amount of fecal matter passed with enema; no results from saline cathartics; vomiting increased; thirst became pronounced. Saw patient three days after vomiting began. She was in bed, restless, vomiting at short intervals and complaining of abdominal pains.

#### Blood Chemistry:

Hydrogen ion	7.7
--------------	-----

Carbon dioxide	50 vol. %
Chlorides	530 mg.
Sugar	166 mg.
Nonprotein nitrogen	50 mg.
Creatinine	1.5 mg.

As blood chemistry showed a decided alkalosis advised that surgeon operate at once. Diagnosis—obstruction in small gut—confirmed by operation. The obstruction relieved, patient made an uneventful recovery.

The cases cited show conclusively how an alkalosis is often interpreted as an acidosis and treated as such with fatal results. Unfortunately, we have become accustomed to think in the terms of acidosis in cases of collapse with vomiting following operations. While as a matter of fact, the probability is, that the case will be one of alkalosis oftener than one of acidosis. For years, we have been basing a diagnosis of acidosis on the finding of acetones in the urine. We often get acetones in the urine without any marked disturbance of metabolism. It is often found in cases of carbohydrate starvation, or less intake than is required to balance the metabolism. The only positive way to determine the difference between an alkalosis and acidosis is by blood chemistry.

Case 3. Mrs. K., young married woman, robust, well nourished, was brought into hospital with abdominal pains and rise of temperature. Case diagnosed as pus tubes. Patient remained in hospital seven days before operation; an alkaline mixture was given several times daily with the idea of preventing an acidosis after operation; uterus, tubes and ovaries were removed. Patient stood operation well; had the usual run of slight temperature and nausea. On fourth day after operation began to vomit, was restless, anxious, twitching of hands, cramps in extremities; teaspoonful doses of sodium bicarbonate were given with the result that vomiting became incessant with profuse diarrhea; with increased listlessness and stupor, patient became much worse in every respect.

On fifth day was called to see patient.

#### Blood Chemistry:

#### Blood Chemistry:

Hydrogen ion	7.6
Carbon dioxide	48 vol. %
Chlorides	500 mg.
Sugar	214 mg.
Nonprotein nitrogen	100 mg.
Creatinine	2.8 mg.

The urine output in twenty-four hours was 31 c.c.

## Urine Chemistry:

Hydrogen ion	4.95
Ammonia	0.02 gm.
Chlorides	0.005 gm.
Urea	0.3 gm.
Albumin	Heavy trace
Indican	Heavy

The laboratory findings showed the patient to be alkalotic. The treatment instituted was insulin to take care of the failing metabolism of glucose, as shown by the 214 mg. of blood sugar, with normal salt solution, one liter every six hours under breast. A glucose solution was also injected at the time insulin was given. The patient vomited only twice within the next twenty-four hours. At this time another blood chemistry was made.

## Blood Chemistry:

Hydrogen ion	7.4
Carbon dioxide	58 vol. %
Chlorides	460 mg.
Sugar	250 mg.
Nonprotein nitrogen	86 mg.
Creatinine	2.5 mg.

## Urine Chemistry:

Volume	400 c.e.
Hydrogen ion	5.6
Ammonia	0.12 gm.
Chlorides	0.24 gm.
Urea	1.10 gm.
Albumin	Negative
Indican	Heavy

The urine output continued to increase daily, patient improved, vomiting ceased. On seventh day another blood test was made.

## Blood Chemistry:

Hydrogen ion	7.35
Carbon dioxide	58 vol. %
Chlorides	525 mg.
Sugar	150 mg.
Nonprotein nitrogen	33 mg.
Creatinine	2.5 mg.

## Urine Chemistry:

Volume	3500 c.e.
Hydrogen ion	6.4
Ammonia	0.14 gm.
Chlorides	2.1 gm.
Urea	11.6 gm.
Albumin	Negative
Indican	Negative

Within ten days patient was sitting up. This case was alkalotic from intake of alkali. The lesson to be learned from this case is the fallacy of giving alkalies before operating with the idea of preventing an acidosis. As a matter of fact, the probabilities are that more post-operative cases have an alkalosis than an acidosis.

Conclusions in cases 1, 2 and 3: There is a definite acid-base relationship existing as shown by the hydrogen ion, CO<sup>2</sup> volumes per

cent, and the plasma chlorides. This relationship will usually run true in cases of alkalosis dependent upon an intestinal obstruction or an excessive intake of alkalis. Why we get a very low sodium chloride in these cases has not been satisfactorily explained. It is claimed by some authorities that it is due to the vomiting of hydrochloric acid; by others that it is due to the chlorides being used as a buffer to neutralize some toxine that is absorbed from the intestines—the alkalis of the intestines or some bacterial product. It will be shown in case 4 that vomiting alone as the cause of the low plasma chloride is not correct. The finding of acetones alone in the urine should never lead to the conclusion that the patient has an acidosis: the ammonia content is of far greater value as a basis for diagnosis.

Treatment: The treatment of post-operative vomiting and collapse cannot be applied by rule of thumb, but must be based upon the findings in blood and urine chemistry. The low plasma chloride in alkalosis is an indication for the giving of normal salt solution in large quantities, about 1000 c. es. every 6 hours, under the skin or in the vein, especially if the patient is dehydrated. In the meantime, watch the heart and kidney action—do not drown the patient. It is often advisable to alternate with a Ringer's solution to which may be added an additional amount of calcium chloride—about 40 grams to the liter. Glucose administered in conjunction with insulin in these cases is of great benefit when there is a high blood sugar or nonprotein nitrogen, as sugar is a good diuretic. There is an interdependence evidently existing between the internal secretions and the functional ability of the excretory organs, therefore, the guide should be the blood and urine chemistry findings, then assist, as far as possible, a failing metabolism.

Case 4. Pernicious vomiting of pregnancy: Mrs. R. L. T., young woman three months pregnant, vomiting since first month of failure to menstruate. For three weeks patient had not been able to retain anything. She was emaciated, mouth dry, breath foul, tongue coated, pulse rapid and thready, breathing rapid and sighing. Three years previous she had had the same experience and was aborted at third month.

## Blood Chemistry:

Hydrogen ion	7.0
Carbon dioxide	34 vol. %
Chlorides	615 mg.
Sugar	125 mg.
Nonprotein nitrogen	36 mg.
Creatinine	1.5 mg.

The acetone in plasma and urine was very



heavy; the ammonia content of the urine was high. This chemistry showed a definite acidosis. Treatment: 90 grams glucose under breast, in 30% solution, simultaneously giving 8 units insulin to be repeated every four hours. Vomiting ceased after first administration of glucose and insulin. The next day patient was given basic diet. A second blood chemistry was made on the ninth day.

#### Blood Chemistry:

Hydrogen ion	7.4
Carbon dioxide	62 vol. %
Chlorides	555 mg.
Sugar	185 mg.
Nonprotein nitrogen	40 mg.
Creatinine	1.8 mg.

The treatment was discontinued, as patient refused to co-operate with physicians, with the result that she relapsed and was finally aborted. This case was an acidosis due to a carbohydrate starvation caused by the inability to retain food for several weeks.

#### Conclusions:

There seems to be a definite relationship in the plasma chlorides, hydrogen ion and  $\text{CO}_2$  combining power of the plasma: the chlorides are high in an acidotic condition—unless patient has been on salt free diet—and low in an alkalotic condition.

In cases of persistent nausea and vomiting, which produce a state of starvation, there is an acidotic condition without a reduction of plasma chlorides, with a definite swing of the hydrogen ion toward acid side with a low  $\text{CO}_2$  combining power of plasma; while in nausea and vomiting, due to intestinal obstruction with absorption from intestinal tract, there is a definite reduction of plasma chloride with a swing of the hydrogen ion toward the alkaline side with a high  $\text{CO}_2$  combining power of plasma.

The indiscriminate administration of sodium bicarbonate, glucose and normal salt solution, without regard to the hydrogen ion,  $\text{CO}_2$  combining power of plasma, and plasma chlorides is meddlesome therapeutics.

#### BIBLIOGRAPHY

- Physiological Chemistry, Matthews.  
 Physiology & Biochemistry, McLeod.  
 Acid Base Equilibrium, A. E. Lehler.

#### Discussion on Paper of Dr. John W. Daniel

DR. HAL McC. DAVISON, Atlanta, Ga.: I am glad Dr. Daniel brought out one point which has given rise to much confusion, and that is that we cannot tell by examining the urine what the blood will show in the chemical analysis. Acetone in the urine does not mean acidosis in many instances. The objection to blood chemistry in the past has been that it requires a large outlay and an extremely well-trained technician. This has been changed by the fact that laboratories are now scattered over the country, with capable workmen. Hospitals are much more frequent and in every one there is some sort of a laboratory where technicians can be trained. Blood chemistry in the diagnosis of acidosis is extremely important. Pediatricians were the first to recognize this. They used to treat summer complaint with alkali and call it acidosis. Following this they found that the alkalies produced more vomiting and other complaints than anything else. The surgeons also discovered this and are now using  $\text{CO}_2$  combining power of blood plasma for the diagnosis of acidosis. This analysis can be done in an hour by a technician who has been trained to do the work.

I am very glad to have been here and heard this paper and am anxious to learn more about the subject.

DR. W. H. MYERS, Savannah, Ga.: I was very glad to hear Dr. Daniel bring out the subject of alkalosis so strongly and think it will do much good. We have been talking for a long time about acidosis. A great many of the post-operative conditions, particularly vomiting, have been called acidosis, and I have no doubt but that a great deal of harm has been done in these cases by giving the very substance of which the patients already had a superabundance. I think Dr. Daniel is working on the right line and I hope what he has said will bring forth good results, as I believe it will.

DR. CLEVELAND THOMPSON, Millen, Ga.: I was glad to hear Dr. Daniel's paper and wish to emphasize it by recounting my experience along this line. In talking on alkalosis and acidosis one immediately gets into deep water, so much so that I, personally, understand very little of what I read on the subject. When this question of acidosis was first brought into prominence in my part of the state, the profession was swept off its feet by an acidosis phobia. Immediately it became popularized, and still is to a certain extent, both among the laity and the doctors. The usual practice was to put a teaspoonful of cooking soda in a large glass full of water; and only this to be given for drinking in all

eases of stomach and bowel upset, as a prophylaxis against acidosis. The patient was to be encouraged to take as much as possible. Since a teaspoon can hold one hundred and ninety-five grains of soda, it will be seen immediately what an enormous amount some of these children are taking.

I have a big score against this acidosis phobia. In that right away I was led into the unfortunate occurrence of killing a patient with soda. He was taken suddenly with a moderate bowel upset; and in collaboration with an eminent consultant, I put him on the soda treatment. The mother was told to give only the soda water and to encourage the taking of as much as possible. An excessive dose of soda sometimes creates an insatiable thirst and produces a violent hydragogue catharsis, so that the infant will take as much as four ounces of the solution at a gulp. This happened in my case, and in seven hours he had taken seven glassfuls of the soda water, was hopelessly moribund and in acute tetany.

Recently a four-year-old child that had a moderate diarrhoea, was put on the acidosis prophylactic treatment by her mother. A large amount was taken; and in a few hours the whole family, panic stricken, rushed into my office with the child in acute tetany from alkalosis. Another two and a half year old infant seen recently in consultation was moribund because the doctor had ordered soda water and an excessive amount had been given. These cases indicate that the practice is still more or less general; and it is an almost daily occurrence to have a patient come in and announce, "Dr. I have acidosis," or "Dr. Soandso says I have acidosis," or a mother calls up and says, "Dr., my child has several sores from acidosis, what must I do for him." The pharmaceutical houses have taken advantage of this situation; and almost daily the mail brings samples of Bisodol, Tri-basic-citrocarbonate, et al et ad nauseam. When will we stop this pernicious practice? Who will bring an efficient protest against it? Apparently the ones responsible for the situation haven't done it. To give soda discreetly, one must know a lot about physiologic chemistry—and in the individual patient, too. Indeed, it is a long hark from the addition of two grains of bicarbonate of soda to each ounce of food for infant feeding, as was the practice in 1909 when I was graduated in medicine, to the addition of acids which we now find so much more beneficial.

DR. JOHN W. DANIEL, Savannah, Ga., (closing): I wish to thank the gentlemen for their very favorable discussion.

I wish to call the attention of surgeons particularly to the point I have tried to empha-

size—alkalosis in post-operative conditions. Many cases of post-operative vomiting, especially where the vomiting comes on five or six days or a week, or even as late as three weeks, after operation, as I showed in one case, is the result of an alkalosis produced by an intestinal obstruction.

Alkalosis may occur in any one of three conditions: the excessive intake of alkalis, deep X-ray therapy or intestinal obstruction. Bear this in mind. If a patient, who has not had deep X-ray therapy and has not had an alkaline intake, is operated and begins to vomit after a period of quiescence, it is very likely a case of intestinal obstruction which is causing an alkalosis.

It has been found that in the alkalosis of intestinal obstruction there is a dissociation between the interdependent variables—carbonic acid gas, hydrogen ion and sodium bicarbonate and the blood buffers. There is also a high combining power of the  $\text{CO}_2$ ; a swing of the hydrogen ion to the alkaline side, with the additional finding of a low plasma chloride, which will often fall as low as 300 mgs. to 100 c. c. of plasma.

When the laboratory findings show this clinical picture, following an abdominal operation, there is an obstruction. These findings will apply equally to an obscure case of persistent vomiting which may be induced by volvulus, strangulated hernia, intussusception, etc., causing an interference with the intestinal function, with the resulting absorption of intestinal contents or the toxins which upset the interdependent variables and the buffers.

#### ANTAGONISTIC ACTION OF POSTERIOR PITUITARY EXTRACT AND INSULIN

From work performed on diabetic patients, Robert C. Moehlig and Harriet B. Ainslee, Detroit (Journal A. M. A., May 9, 1925), believe that pituitary extract injections improve the muscular asthenia to a great extent. This is true despite the fact that the patients, for the purpose of the work, are not placed on a diet. Patients with hypopituitarism suffer from asthenia, and fatigue is easily induced. The opposite is true in cases of hyperpituitarism. Posterior pituitary extract injected into normal rabbits produces, as a rule, a slight rise in blood sugar. Posterior pituitary extract, when injected simultaneously with insulin, prevents the fall produced by the latter. Posterior pituitary extract, injected during insulin hypoglycemic convulsions, produces a rapid rise in blood sugar, with subsequent recovery of the rabbits. The point of attack of the pituitary extract seems to be in the periphery: viz., the skeletal muscle metabolism.



**PELLAGRA AND ITS TREATMENT\***

L. L. Whiddon, M.D.  
Ocilla, Ga.

**DEFINITIONS:**

Pellagra is not a disease but is a diseased condition of the body metabolism expressing itself, typically, by an erythematous roughening and burning of the exposed parts of the skin, stomatitis, diarrhea, marked nervous disturbance, and in the end insanity.

**ETIOLOGY:**

An enormous amount of effort has been directed to the elucidation of the cause. Many suggestions have been made and theories advanced, but to my mind it all sifts itself down to a **PROTEIN STARVATION**. Up to the present, even with all the work of Goldberger and other noted men, we are not far from the original suggestion that its cause was "BAD FOOD." Goldberger and others say it is an unbalanced diet and at the same time I can take an unbalanced diet and cure it, which seems to disprove their statements.

All indirect causes of pellagra, whatever they might be, point to one fundamental cause, e.g. **PROTEIN STARVATION**.

I am purposely going to classify pellagra at this point, because it is only from an etiological standpoint that it is possible to do so. We have two main heads under which the condition comes which are as follows:

First, where the patient's protein diet is partially or totally inadequate.

Second, pellagra where the patient's protein diet is sufficiently adequate and yet he has pellagra. This right here is the most puzzling part there is about pellagra to understand.

In the first class you get pellagra in the poor, the finical eaters, and the prisoners whose diet is poorly planned. You may also find it in the over-economical.

The poor either cannot buy protein food at all or if they do it is in the form of bacon which is very poor in the lean or more essential protein, and to further decrease the value of it they fry it when it ought to be boiled. To my mind fried food is markedly



Fig. 1. One of 46 cases I have treated with the same results. This case was unable to walk but was better at the time of this picture, which was 3 days after first visit. This is one of my worst cases and her stomach had to be cocaineized so that the food could be retained long enough to be digested.

decreased in value. Some of the reasons why the poorer classes fry their food are to save time in the preparation, lack of knowledge of domestic science, laziness, etc. Bear in mind, however, this is one of the main indirect causes of pellagra. This is especially true in the negro race.

The finical eater, due to the lack of knowledge of the importance of protein food, will partake mostly of the more tasty foods and naturally this leads them to the sweets and starches. If a person has or thinks he has indigestion in any form, due to the fact that there is a false impression spread abroad by physicians about the harm of meat and meat is the only protein in many families because they sell their eggs and are prejudiced against milk, the first thing he or she thinks of is that meat is the offending article and cuts it out. If a person has a little too much circulatory pressure, "chronic headache," "liver trouble," "kidney trouble," "bladder trouble," "body trouble," "leg ache," or "toe ache" his family physician immediately, off-handedly, tells him or her to cut

\*Read before the Medical Association of Georgia, May 13, 1925.





Fig. 2. Same case as Fig. 1. Sixteen days after beginning treatment. Note arms slick and ulcers filled in on insteps. Patient got up, dressed herself and walked out for the picture.



Fig. 3. Same case as Figs. 1 and 2. About 82 days after treatment. Note the cicatrix on arm of left side and knuckles on right hand.

out meat, and of course, meat being the only protein many eat, naturally his patient sooner or later develops pellagra. Nine times out of ten, not meat alone was the cause of his patient's trouble, but RATIONS, for we, almost all of us eat too much.

The prisoners' diet many times is devoid of protein due to graft and to the lack of financial appropriations. Other foods being cheaper there can be a cut in expenses by leaving out the protein.

In the over-economical you will find their table set without the important protein due also to the high cost of proteins. There are many parents, however absurd it may sound, who will not let their families have meat more than once a week and then generally it is fried bacon. There is more extravagance and waste in the dining rooms of this world through the eating of bacon than any other one thing. Under the cloak of economy is worn the coat of extravagance.

Now in the second class there are many, many different conditions which come in to take part in the production of pellagra. Some of them are as follows in the order of importance: Malaria, hook worms, child

bearing, syphilis, tuberculosis, over work, constipation, arteriosclerosis, cancer, surgical operations, other emaciating diseases, idiopathic, etc.

In all of these conditions pellagra is of course only secondary. The power of protein digestion is so lowered that the patient will have pellagra even though his diet is made up almost wholly of proteins. This fact is what has held back the progress of science in elucidating the cause and treatment of pellagra, and is what has to a major extent, prompted Robert M. Thompson's Pellagra Commission of the New York Post Graduate Hospital and others to advance the infectious theory, also Joblin and Arnold to bring forth the view of the absorption from the intestinal tract of Photodynamic substances, produced by certain fungi, when the diet consists largely of carbohydrates, being the cause.

The way in which these conditions produce pellagra is that they are such a drain on the human system that they interfere with the normal physiology of digestion by reducing the function of the parietal or acid cells in the fundus of the stomach which

cells secrete (HCl) Hydrochloric acid. This acid being the most important gastric juice in the primary digestion of proteins, especially meats, when its production is reduced you have an interference with the further digestion and utilization of proteins regardless of how much is taken into the stomach. Now, of course, if a patient cannot utilize a food it is the same as if he had not eaten it. Why a patient will have pellagra on a full and sufficient diet is what has been puzzling pellagra investigators everywhere. On page twelve-fifty (1250) of the A. M. A. Journal of last month is reported by W. L. Bender, San Francisco, three cases upon which operations were done on the stomach interfering with the primary digestion of foods who developed pellagra even though they received, technically, ample protein and in whom the pellagra symptoms immediately cleared up while taking the same amount of protein as soon as their digestion improved sufficiently.

#### SYMPTOMS:

Now, just a word of warning about the symptoms of pellagra. The name itself is a misnomer from its root meaning for the condition. "Pelle Agra" meaning rough skin will only fit the condition in about thirty or forty per cent of the cases. The definition gives you in a nutshell the symptoms of a typical case, but we do not have typical symptoms except in about thirty to forty per cent of cases. I have had patients to come to me with only a tingling and itching sensation all over their body with or without a loss of weight, also, with only dementia. Others have come with only a chronic indigestion as they thought, while others with only a "down and out feeling" as they expressed it. Some have come with too much gas in the lower bowels with its attending colic and "rumbling sounds." This is a very important atypical symptom and is due to food passing out of the stomach undigested forming gases and toxins in its route, when if it was digested it would not do this. A digested food is harmless comparatively speaking. Always be on the lookout for pellagra for I have not named all the atypical symptoms that you will run across in the condition. So, when in doubt, do as I do. Make a therapeutical diagnosis, the same as

in malaria with quinine. An almost pathognomonic sign. I will say, is for a patient to tell you he or she has not had "sour stomach," "heart burn," or "sour belch" for over five or ten years.

#### TREATMENT:

In the treatment of pellagra, as it is practically always secondary to other diseases, naturally, the first thing to do is to put your patients to bed and find out what is the primary cause and treat it, and, if the cure of the primary cause is immediate, the pellagra will automatically clear up without further treatment.

As far as curing pellagra is concerned, there is no more a cure for pellagra than there is a cure for starvation. If a man is dying from a whole food starvation, you can save his life, or, cure him, so to speak, by giving him food, but as soon as you cut off the food again and keep it off your patient will die of starvation. It is the same story with pellagra. A pellagrous patient is starving for protein food, therefore, if you give him proteins and help him digest it, if he needs help, you will stop the pellagra, but you have not cured him in the same sense that you cure diphtheria with an antitoxin or malaria with quinine, for, just as soon as you stop the treatment, your pellagra is bound to return.

My direct treatment for pellagra, being so marvelous in its effects, even as much so as "606" in syphilis and yet so simple, is what has inspired me to write this paper. Goldberger says give them a balanced diet and Dr. Stewart Roberts says forceful feeding of a balanced diet, but, as I said before, I can give them an unbalanced diet and relieve any case of pellagra of practically all symptoms in twenty to thirty days. I think every one under the sound of my voice will agree that boiled lean ham meat alone is an unbalanced diet, but, gentlemen, boiled lean ham meat, all your patient will eat, with one half to one dram of dilute hydrochloric acid in one half to one glass of water immediately after eating the meat, when you think they need the acid, that is, in very weak and emaciated patients and in whose diet there has been ample protein but yet they have pellagra, will relieve any and all of your patients of pellagra even though



you do not treat or relieve them of their primary cause, but it makes pellagra much easier to handle to get rid of the primary cause. The above fact alone proves the efficiency of my treatment.

The hydrochloric acid is only a prop, so to speak, the same as you would place under a withered flower until it can take on new vigor and strength. Therefore, as soon as the flower gets enough rain, sunshine and plant food to give it sufficient strength to support itself, you may remove the temporary support and it will grow on showing its strength and beauty, and revealing the handiwork of the Almighty Creator, but you cannot remove either the rain, sunshine or plant food, or your flower, which would be beautiful, if it had a chance, will surely die. I am not here to say that only boiled ham meat for your protein will do this work. I am sure that any protein will answer almost as well as boiled ham meat, but this meat I find more effectual and easy to obtain. Therefore having tried other things but they did not give me as gratifying and immediate results as boiled ham, I was constrained to go back to my meat which works like a charm.

In some of Goldberger's and Tanner's last reports they suggest that the trouble is an amino-acid deficiency and as this is some of end products of protein digestion, I am sure they are now on the right road, for a protein deficiency and an amino-acid deficiency means approximately the same thing.

I am not prepared to say whether the patient needs vitamin A. B. C. or Z. as for that which he extracts from the meat, but I do know he needs boiled ham meat, all he can eat, every day and every week.

#### Discussion on Paper of Dr. L. L. Whiddon

DR. J. W. PALMER, Ailey, Ga.: I wish to thank Dr. Whiddon for his paper. I have often wondered why there are so few papers on pellagra when we have so many cases of pellagra in Georgia. I differ with the Doctor somewhat in his treatment. I congratulate him on his thorough study of the subject. The cause of pellagra is not known. We know there are three chains of symptoms, the mental, the gastrointestinal and the skin. I am impressed with the fact that we have a

great many more cases of pellagra than we think. Most of us can make the diagnosis of pellagra when the skin eruption is present, but many of us treat pellagra for something else without knowing it. I was impressed with the report of the patient with pellagra who was sent to an eminent stomach specialist who treated him for ulcer of the stomach until the patient was finally told that he would have to be operated on. He came home to prepare for operation and while he was at home the eruption appeared and that saved him from operation. This is an example of how the best men can be mistaken.

I have several pellagrins under observation who return at intervals of every 1 to 3 years, and this year I have had more of these patients to return than ever before. I have found that pellagra occurs periodically—every three or four years, and have noticed that the condition is always more pronounced in the Spring than in any other season.

Regarding the treatment of pellagra, I find that we have to treat the patient and not the disease. I have tried a great many things and have been in touch with all those who have written papers on the subject. Things that will help some patients will not help others. As to Dr. Whiddon's panacea, lean meat and hydrochloric acid, it will work on some patients, but make some others worse. I find nothing that quiets my patients, particularly those with the nervous symptoms, more than sodium bromid and milk of magnesia. I find that this will usually give temporary relief, until we can give more permanent relief by diet, rest and other drugs. I also believe that keeping them out of the sunshine and in the shade is of advantage in all cases.

DR. J. M. POER, West Point, Ga.: We have pellagra with us all the time and up to this time our best scientists have not given us a cause for the disease or a remedy. I would like to have Dr. Whiddon tell us how he knows he has cured the disease and eradicated it. You simply know you have treated the symptoms and that they disappear, but I have had symptoms recur in the same patient after three or five years identically as they were at first. We first thought this was due to some germ and was probably contagious because there would often be several cases in the same family. Then we thought that perhaps some inherited factor was responsible for it, like syphilis, and we next thought it was infectious because it spread from house to house. It was also thought to be due to food because many of the poor people live upon canned products and we believed these formed the source. Some have suggested that if people have milk they will never have the disease. Others said they should have meat and one man said he cured all his cases by giving



them green apples. The patients often recover from this condition if they are given nothing. In the case of digestive disturbances in the absence of hydrochloric acid in the stomach some men have suggested that if dilute hydrochloric acid is given it will give wonderful relief. I think if Dr. Whiddon would try just the hydrochloric acid and not the meat, but give a regular diet, he probably would have the same result. Others have had that experience. With the same treatment and the same symptoms they will come back and we are still where we were. We are simply treating the patient, as Dr. Palmer said.

One thing has been known to be of value for a long time and that is arsenic. Dr. Bass has suggested probably the only sensible thing, that it is due to a low plasmodia floating in the blood, something like malaria, and then these poorly nourished people with greatly lowered vitality develop these symptoms, as they will develop in malaria or any other disease that stays in the body for a long period of time. When these devitalized conditions are present the symptoms of pellagra will appear. Arsenic in some form, cacodylate of soda, arspenamin, or arsenic in some other form has been the only thing that has given me satisfactory results. Along with that, giving them the regular, normal diet, treating the symptoms symptomatically and trying to get the patient well, to my mind, is the proper treatment. When the cause is finally arrived at I think it will be found that it is a low plasmodia condition which remains in the body for a long time, like syphilis and malaria. We all know that the patients who have been reported cured with green apples and with milk and eggs or meat and nothing else have a recurrence of the disease.

DR. H. C. WHELCHER, Douglas, Ga.: I am up here to ask a question. While I have been in practice for quite a number of years I have not seen much of pellagra in the last four or five years, and I wonder if this is the experience of other doctors here. It has seemed to me that the disease has been lessening. I have attributed this decrease to the balanced diet that has been mentioned.

DR. DANIEL S. MIDDLETON, Rising Fawn, Ga.: It is evident to me from the ear-marks that this disease bears that it is a distinctly infectious disease, as much so as tuberculosis. The profession was a long time learning that tuberculosis is a distinctly infectious disease. While Goldenberger and Lavender and many others have written a lot on this subject don't agree to this, they do not prove to me, after my experience with this disease, that it is not a distinctly infectious process.

It has also been my observation that pellagra is less frequent than it was ten years ago.

In industrial districts ten years ago pellagra was quite frequent. To my satisfaction I have been able to trace the origin of a number of cases to one patient who had come from some other industrial center. As I understand, it came originally from Italy where it had existed for a long time and the emigrants brought it to this country and the sections where the Italian emigrants were employed developed the disease. Studying the history of this disease and the time it appeared in the United States proves to me that if there ever had been a time when pellagra should have spread over the country it was during the war periods of the past when food was scarce. During the Revolutionary and the Civil Wars if the disease was here then why were the soldiers not all stricken with pellagra while on their famous marches? The soldiers all came through with good nervous systems, a good clean skin and no marks of pellagra.

As to treatment, the more I treat it the less I know. I have thought several times that I had cured some of the patients. I used cacodylate of soda, first hypodermically and then intravenously. This helped my patients but did not cure them. I think a devitalized condition, shock and so on are sufficient to precipitate an attack. The nervous cases are found in the insane asylums and we often do not know until the eruption appears what is the matter with the patients.

DR. NEAL KITCHENS, Warm Springs, Ga.: When these cases first appeared I did not attempt to treat them because I did not know what the trouble was, but on account of an observation by Dr. Blanford who was city physician in Columbus several years ago, I have tried typhoid vaccine. The patients are still well and pellagra has disappeared from my district.

DR. L. L. WHIDDON, Ocilla, Ga., (closing): I am very glad, as enthusiastic as I am about it, and as sure as I am that I am on the right road, I am glad that you all differ with me because, if I am right on this subject, that means that I am a little ahead of you.

Dr. Palmer said the cause was unknown. I agree with him so far as coming down to actually proven, accepted therapeutic proof. He said it appeared more frequently in the Spring, but the hotter the days the more pellagra there is. The case is that in the summer time we need more protein and less carbohydrate and in the winter more carbohydrate and less protein.

The next discussant, Dr. Poer, wanted to know how I know the patient is well. Because he does not die, but is alive and at work. The pellagra patient is starving from lack of proteins. See what happens if you

feed pigeons on rice alone. They are not sick but they die. Of course the condition will return the same as starvation will if you take the food away, because it is a starvation and not a disease. You remember hog killing comes in the fall of the year. That is why pellagra gets better in winter, because it is then when they get more ham. I have a patient now whose husband is so stingy that he will not give her meat. He would rather come to me for medicine, but every year as soon as hog killing time comes she gets well and stays well as long as she has protein (ham).

One of the doctors asked about giving hydrochloric acid alone in some cases. If the doctor had given strict attention he would know that this was explained thoroughly in my paper. That will cure in some cases because some patients have not enough hydrochloric acid and they have pellagra, and that is due to the fact that there is something there that is interfering with the production of hydrochloric acid and giving the acid will cure them.

Dr. Middleton said that pellagra is a specific disease. The infection being transmitted from one to another thru contact; beginning in Italy, it spread to other parts of the world through contact. I want to say that about all of our diseases originated in Europe, but there is no proof that pellagra is a specific disease. Did not beriberi originate in China? Did not scurvy originate on the ocean when traveling was slow and voyages long and the sailors lived upon dried foods? Now both these conditions have been seen in this country, but does that mean that they are infectious diseases? Not at all, and neither does the fact that pellagra, originating in Italy, prove that it is an infectious disease.

I thank you very much.

#### KETOGENIC DIET IN EPILEPSY

Thirty-seven patients with essential epilepsy have been treated by M. G. Peterman, Rochester, Minn. (Journal A. M. A., June 27, 1925), for periods of from three to thirty months by means of a high fat diet sufficiently restricted in carbohydrate and protein to produce ketosis. In two patients, no change was noted. One patient improved while under control, but was lost from observation. Three patients remained free from convulsions for from three to eight months, and were then not heard from. Twelve have improved, and nineteen have been free from attacks since the institution of this treatment. Thirty-two of the patients are still under observation. The general physical development and growth have been normal; the mental development, has also been normal, and exceptionally good in certain cases. Resistance to infection seems to be in no way diminished by this form of treatment. Special attention is called to the fact that five of the patients have gone through severe infections, including scarlatina, pertussis and acute upper respiratory infections, with normal convalescence. The diets were not altered during the illnesses.

## HEMORRHAGE IN PULMONARY TUBERCULOSIS\*

Champneys H. Holmes, M. D., Atlanta, Ga.  
Definition

The term hemoptysis is rather vague quantitatively, meaning anything from blood streaked or blood stained sputum, to copious hemorrhage. In the main, the term hemorrhage is used here to designate the spitting or coughing up of fluid blood from one draehm to a pint or more in amount.

### Incidence and Etiology

Of the conditions in which hemorrhage from the lungs occurs, pulmonary tuberculosis stands out in bold relief. It is the one disease, above all others, in which this alarming symptom is so often encountered. In every case of pulmonary hemorrhage, consider it tuberculosis, until proved otherwise. Obscure blood spitting is almost always due to tuberculosis, and at this juncture, I would like to quote Dr. Cabot's admonition where he says, "I do not deny that the causes of hemoptysis are numerous, but I assert that the causes of genuinely obscure hemoptysis in temperate climates may be reduced to one—pulmonary tuberculosis." Dr. James A. Miller, of New York City, in his lecture to the Columbia Medical Students, cites the following figures: 95% of all cases of hemoptysis come from the lungs, and in turn 95% of all hemoptysis from the lungs is due to tuberculosis. Stricker, in reviewing the causes of hemoptysis among the Prussian troops, reports a figure of 95.8% as due to pulmonary tuberculosis. Dr. Richard Cabot, in the Massachusetts General Hospital records, reports that tuberculosis is responsible for 50% of the cases of hemoptysis with cardiac disease running a relatively close second. There seems to be some discrepancy between this figure and the ones given above, and is explained in this way. No frank cases of pulmonary tuberculosis are admitted to this hospital, while again decompensated cardiacs make up a large per cent of the total admissions to this or any other general hospital. In cases of blood spitting, physicians are prone to ascribe to lesions in

\*Read before the Fulton County Medical Society, November 20, 1924.



the nose and throat or other parts of the upper respiratory tract, the source of the bleeding. This is a grave error, and while it may comfort and allay the fears of the patient at the time, in the long run it works untold harm, in the fact that the true nature of the malady remains unrevealed and the proper treatment instituted at an unfortunately late date. I would like to emphasize once more the fact that hemoptysis or hemorrhage from lesions in the upper respiratory tract is rare; and to lament the fact, that in spite of this, it is probably the most commonly accepted explanation by physicians treating these cases. When such lesions are the source of the bleeding, they are usually small varices or tumors in the naso-pharynx or larynx. Although performing a minor role in the general incidence, there are numerous other causes of pulmonary hemorrhage than tuberculosis. I shall suffice in merely mentioning some of these, namely: trauma, pulmonary infarction, heart disease, influenza, pneumonia, lung abscess, bronchiectasis, aneurysm, neoplasms; and more rarely, hydatid cyst, mycotic infections, pneumoconiosis, pulmonary distomiasis, spirochetal bronchitis, etc.

### Differential Diagnosis

Upon encountering a hemorrhage case, the chief problem that confronts us is that of differential diagnosis, and the questions requiring solution are: Is the bleeding from the lungs? is it due to tuberculosis? and, last but not least, from which lung? This last point is a very important one, often extremely difficult to decide, and even at times impossible. In solving these problems we have recourse to our several methods of investigation, namely: a carefully recorded history, physical examination, laboratory findings, X-ray and fluoroscopic examination, and in some cases such special measures as bronchoscopy, etc. A good history in these cases is of paramount importance, and in most instances affords very definite information as to the nature of the condition, or offers suggestive clues which then may be developed by the other modes of investigation mentioned. For instance, a history of cough, weakness, loss of weight, and occasional blood streaked sputum, for past two years;

frequent attacks of influenza and bronchitis in the past; a history of pleural effusion and perhaps a fistula in ano ten years ago; a marked family history of tuberculosis; such a history is strongly suggestive, if not conclusive, that we are dealing with a case of pulmonary tuberculosis. Again, a history of a hemorrhage suddenly appearing in a person who up to that event had been well and enjoying good health, is very strongly suggestive of tuberculosis, and should be considered tuberculosis, unless something very definite is found elsewhere to explain the bleeding. Then again, a history involving such symptoms as shortness of breath, palpitation, cough, edema of ankles, etc., would tend to make us think of a cardio-circulatory disturbance; or facts, in the history such as bleeding on other occasions into the skin and mucous membranes, a hereditary factor, etc., may cause us to think in terms of a hemorrhagic diathesis such as purpura and hemophilia. Perhaps the history would focus our attention upon a hematemesia from gastric or duodenal ulcer, or from esophageal varices of hepatic cirrhosis. I might mention here a rather curious observation, and one commented upon by Dr. Louis Hamman of Baltimore—hemoptysis is frequently mistaken for hematemesia, but the reverse appears to be very infrequent.

In submitting patients with pulmonary hemorrhage to physical examination the strictest caution should be exercised, since the slightest exertion and trauma incident to this procedure frequently precipitate a copious and alarming hemorrhage. I have observed on several occasions such an unfortunate happening following an indiscretion on the part of the ambulance surgeon. In some of the tuberculosis institutions, where large numbers of these cases are treated, the patient is put to bed on admission and no examination of chest is made until the sputum is free of color for several days. In making a chest examination on these cases, it has been my custom to rely almost entirely upon quiet auscultation; for percussion, even of the light variety, and having the patient cough, are dangerous procedures. In pulmonary tuberculosis, pathology of any considerable extent can be appreciated by



auscultation; and when unilateral,, informs us from which lung the hemorrhage most likely takes place. In bi-lateral disease, the side of the most extensive lesion and particularly the most moist, is usually the offending one. In other cases, the presence of moist rales extending toward the base, due to aspirated blood, may be the deciding factor. Very often it happens that the patient himself can tell from which lung the bleeding takes place, there being such subjective sensations as a rattling or gurgling in that side, or as they sometimes state, they have a "queer feeling" there. Such fortunate information is not always forthcoming, but when it is, it is in the majority of instances reliable. At times the problem may be extremely difficult of solution, and here roentgenology may be of the greatest assistance. There are however some cases, in which even this, together with all other methods, are fraught with failure. Roentgenology is best performed either by means of a portable X-Ray unit or the recumbent fluoroscope, thus imposing the minimal amount of physical exertion upon the patient. From the laboratory, the greatest aid in these cases, is derived from the examination of the sputum. Where repeated sputum examinations are negative for the tubercle bacilli, other causes than tuberculosis should be considered. At this point, I would like to express a dictum, which while it embodies facts fairly well appreciated, is not sufficiently stressed I take it, to make this emphasis here amiss; namely: in the presence of extensive pathology in the lungs, with many physical signs and large amounts of expectoration; a negative sputum almost rules out pulmonary tuberculosis. In the various text books, a good deal is read about the foamy or non-foamy character of the expectorated blood and its reaction to litmus paper. In my experience these points have been of little or no practical importance, serving merely as ones of academic interest or for teaching purposes.

### General Considerations

There are two false views prevalent among laymen relative to the significance of a hemorrhage in pulmonary tuberculosis. One is that it occurs only in far advanced

cases and that it is a signal for an early termination. The other view, is that the bleeding serves as a mechanism for washing out the impurities in the lungs. A hemorrhage may occur at any stage in the disease, and at the Phipps Clinic at the University of Pennsylvania, Norris and Landis report that over 47% of all cases have had blood spitting at one time or another. Very frequently it is the initial symptom, or occurs in the incipient stage; and in this way it serves as a boon. Undoubtedly there are thousands of individuals today, living and enjoying relatively good health, who otherwise would have been dead, or suffering with far advanced tuberculosis, had it not been for this alarming symptom, hemorrhage, bringing them into the hands of the doctor early in their disease, and at a time when it was most amenable to treatment. The bleeding is most frequently produced by the invasion of a small blood vessel, by a caseating tubercle; or by the rupture of a vessel due to trauma, such as a severe paroxysm of coughing. In a large number of instances the bleeding is purely a mechanical occurrence, and the patient experiences no harm, other than the loss of a few ounces of blood and the psychical shock or going through the ordeal. It is of interest to note that in some individuals who have had numerous small hemorrhages, the incident is viewed with relative indifference, merely an annoying occurrence. In the vast majority of instances, it is attended with a considerable psychic upset. The real and most formidable danger of a hemorrhage, is the spread of the disease by the invasion of virgin tissue with the germ laden blood.

The amount of blood lost in a hemorrhage varies considerably from a few c.c. to as much as a quart or more. On an average, they usually vary from three to six ounces; a hemorrhage of three ounces or less considered as small; from three to six as medium size, and over six considerable to severe. Large hemorrhages are frequently encountered in cavities and in hilum tuberculosis. In the latter condition, there is very often a dearth of physical signs and X-ray findings. I have many times seen patients with copious hemorrhage that on subsequent examination showed absolutely nothing on the physical

examination, and only very questionable findings in the hilus on the X-ray film. Fortunately for diagnostic reasons, a positive sputum in these cases is the rule. It is not uncommon for the patient to swallow some of the blood which can be subsequently detected in the stool. In such an event, of course, the amount of blood lost is greater than is at first appreciated. Severe and even fatal bleeding may take place without there occurring hemoptysis. Osler makes mention of a fatal hemorrhage into a large cavity without there being any expectoration of blood. A brief glance into the sputum cup, or whatever receptacle is being used, gives quickly some idea as to the time relationships of the bleeding. A recent hemorrhage is bright red, fluid, spatters and may or may not be foamy; while older bleeding becomes progressively darker in color, is tenacious, and embedded in mucus. The expectoration may show some color for many days after a hemorrhage, but on an average of about four to five. The duration of a hemorrhage varies considerably and obviously this factor is largely influenced by treatment. The duration may be from a few minutes to an hour or more with the average time, being about twenty minutes. In some cases there may be an oozing lasting over many days or weeks; or there may be many small recurring hemorrhages over a period of several days. The frequency with which a given patient has hemorrhages varies widely and is subject to no definite rules whatsoever. There are individuals who seem to run a so-called hemorrhagic course, and ever so often spill over with a larger or smaller amount of bleeding.

In the consideration of the significance or gravity of a given hemorrhage, there is one point or criterion that I do not believe has been sufficiently stressed in the text books and literature upon the subject. This criterion is the presence or absence of fever accompanying or shortly following the hemorrhage. A rise in temperature indicates in most instances a spread of the disease and therefore materially and unfavorably affects the prognosis.

### Treatment

The first and paramount essential in the treatment of a pulmonary hemorrhage is absolute rest. This does not only mean bodily rest with its resulting effect upon the circulation, respiration and metabolism; but it must include mental and emotional rest which in turn reacts favorably upon these functions. With the advent of a hemorrhage the patient should be immediately put to bed and kept absolutely as quiet and as still as possible, not making any unnecessary movement during the active bleeding period, and for a few days thereafter. Such daily measures as bathing, changing bed clothing and shaving should be withheld. As regards position in bed, there is some difference of opinion, many preferring the patient to lie flat in bed in the supine position, others preferring having the patient propped up on one or more pillows. I think the latter position is preferable in view of the fact that it facilitates the expectoration of the blood as it comes up, and also in that it lessens somewhat the danger of aspiration. Evacuation of the bowels during the active bleeding period should not be secured at the expense of disturbing the patient. Drastic purges and cathartics are interdicted; but mild laxatives and small enemata may be resorted to as occasion demands. As soon as the patient is put to bed, an ice bag is placed upon his chest, and a hypodermic injection of morphine, 1/6-1/4 gr. is administered. This order is a routine in many of the sanatoria.

Atropine is combined with the morphine by many on account of its vaso-motor effect, while others object to it on the grounds of its stimulating effect on respiration. For a long time, the virtues of the ice bag have been attributed to the constricting effect of the cold upon the lung and its blood vessels; but I think it is the consensus of opinion now that in reality it is due to its quieting effect upon cardiac action.

The occurrence of a hemorrhage is an alarming event, and most always, particularly with the first one, the family and neighbors, as well as the patient, are thrown into a panic. Here is a strong indication for the physician to put forth every effort to allay their fear and quiet them. The patient

should be assured that he is not going to die (and a fatal hemorrhage is relatively rare) and that if he lies perfectly quiet and still and does exactly what you tell him he will recover. At this juncture it is a good policy to inform them of how very familiar you are with the condition, and of the numerous cases like it that you have seen and that recovered. This may savor somewhat of the braggart, but it is justified I think in the fact that it possesses decided therapeutic value. Again the physician should not appear anxious and alarmed; but should radiate confidence by appearing cheerful and optimistic, and by that I do not mean disinterested or indifferent. It is by virtue of its quieting effect, not only physically but psychically, that morphine is such an indispensable drug in the treatment of a hemorrhage. It should be exhibited every four to six hours as indicated during the acute phase. No visitors should be allowed and absolute silence upon the part of the patient should be strictly enjoined, the sign language being resorted to when necessary. Placing a sand bag or similar weight upon the affected side, in order to reduce respiratory excursion, is a valuable measure in some cases. Another procedure, with the same object in view, is the controlled diaphragmatic breathing as advocated by Adolphus Knott; and it may be of considerable value provided the source of the bleeding is not in the lower lobes. The outstanding measure along these lines, and of which more will be said a little later, is artificial pneumo-thorax.

The diet during a hemorrhage should consist of cold liquids and crushed ice, with a gradual return to a bland diet during convalescence. Alcoholic and carbonated beverages and hot drinks are strongly interdicted. Tobacco in any form should not be permitted. Drugs exert a beneficial effect in the treatment of pulmonary hemorrhage by virtue of their action in calming the patient; reducing cough; quieting the heart and circulation; reducing pressure, particularly in the pulmonary system, and increasing the coagulation of the blood. The drugs advocated for the treatment of this condition are legion, and the scope of this paper does not permit a detailed discussion of them

and their "modus operandi." A list of some of the more popular drugs recommended, some of which are valuable and others that are without value or even harmful are: morphine, atropine, emetine, ipecac, amyl-nitrite, nitro-glycerine, ergot, calcium salts, bromides, camphor, camphorated oil, hy-drastis, codein, gelatine, mustard, magnesium sulphate, sodium citrate, aconite, tannic acid preparations and chloroform. These are administered by the several modes of administration as oral, hypodermic, intravenous, inhalation and local application. The intravenous injection of a 30% sodium citrate and a 5 to 10% calcium chloride solution have proven of considerable value in many instances. Temporary bandaging of the extremities and hot foot baths have been favorably reported upon by some.

In severe, protracted, and in small persistent and repeated hemorrhages, the outstanding and most reliable method of treatment is collapsing the lung by means of artificial pneumo-thorax. In most instances, the result is little short of spectacular and usually by the third injection of air, if not sooner, all bleeding absolutely ceases. One caution here I think is pertinent. When you collapse a lung in the presence of such an emergency; this collapse should be maintained for a variable length of time, otherwise, with the absorption of the air, the pleural surfaces adhere, and future pneumo-thorax is rendered difficult or impossible, and thus the patient is denied a most important therapeutic procedure, should it subsequently become indicated.

Now in conclusion, a few words relative to prognosis. Of course in a given case the prognosis will vary with the extent, character and duration of the hemorrhage. As pointed out above, the chief significance of a hemorrhage is not the amount of blood lost; but the extent of the spread of the disease, and it is upon this point that the prognosis is chiefly based. Recovery from the hemorrhage itself is the rule; a fatal outcome being the exception. When a hemorrhage results fatally, it is usually those cases where a goodly sized vessel traversing a large cavity ruptures.



**THE JOURNAL**

OF THE  
MEDICAL ASSOCIATION OF GEORGIA  
Devoted to the Welfare of the Medical Profession of Georgia.

---

65 Forrest Ave., Atlanta, Ga.

---



---

OCTOBER, 1925

---

ALLEN H. BUNCE, M. D., Editor

Publication Committee

CHAS. USHER, M. D.

S. J. LEWIS, M. D.

T. C. THOMPSON, M. D.

---

Articles are accepted for publication on condition that they are contributed solely to this Journal.

Manuscripts should be typewritten, double-spaced, and the original (not the carbon copy) submitted. Used manuscript is not returned unless requested.

Communications and items of general interest to the profession are invited from all parts of the State. We especially invite county society secretaries to send us information of happenings in the county that would be of interest to the members throughout the State.

Reprints should be ordered within 30 days after the appearance of an article, since all type will be destroyed at the end of that time.

---

## Editorial Department

### THE BARTOW COUNTY CLINIC

On August 20th and 21st the Bartow County Medical Society rendered a wonderful service to its community. The Cartersville Rotary Club had inaugurated the scheme for examining and treating the school children of Bartow County. The idea spread so rapidly, however, that by the time the clinic was held the whole county was interested in it and in lending every effort to its success. In two days 763 children were examined. The large home of Mr. Dodd Warren was converted into a temporary hospital. Four operating tables and thirty-five beds were set up. One hundred and six children had their tonsils removed in two days and 12 have had tonsils removed since. Forty-eight children had glasses fitted. One case of tuberculosis, 12 cases of hookworm disease and two cases of trachoma were discovered. More than 400 children had teeth extracted. It was stated that the number of teeth pulled amounted to two pecks and the regular surgeons charges would have amounted to over five thousand dollars.

Members of the medical profession who contributed their services were Drs. T. Lowry, Chamblee, W. E. Wofford, S. M. Howell, W. C. Griffin, R. E. Adair, H. E. Felton, R. E. Wilson, A. L. Horton, H. B. Bradford, Hutchingson, Bradley, Stanford Quillian and William Jones, all of Cartersville, Bartow County. Dr. George Smith, of Rome, also lent his valuable aid in ophthalmology. The dentists of Bartow County who participated were Drs. Clark Griffin, Weems, L. L. Lowry, McElreath and Mumford. This was a splendid piece of public health work which could be emulated by other counties of the state.

FRANK K. BOLAND,

Pres. Medical Asso. of Georgia.

### THE SOUTHERN MEDICAL ASSOCIATION MEETING

The various committees appointed in connection with the meeting of the Southern Medical Association in Dallas November 9-12, 1925, report very satisfactory progress.

It is especially gratifying to know the hotel committee has already succeeded in having reserved for guests more than 1600 rooms in the leading and best hotels of Dallas. This insures you that no matter how great the attendance each one will be comfortably and suitably provided with proper hotel accommodations. This settles a question which has not concerned the doctors of Dallas who are acquainted with local facilities, but which has been raised by prospective visitors.

For the first time in its history, the Association will have all its activities housed in one building. The new educational building of the First Baptist Church on the corner of St. Paul and San Jacinto streets will be completed long before November and will have a sufficient number of assembly halls for the various section meetings. The large auditorium with its splendid acoustics gives ample room for all general sessions and the basement floor, easily accessible, will give more than enough room for all exhibits, commercial and scientific.

In connection with the Association's meeting in November, clinics in all branches will be conducted in all Dallas' splendid hospitals, which contribute largely to its rank

as a medical center of the Southwest. The bed capacity in the larger hospitals alone is in excess of 1,200. Over \$8,000,000.00 has been invested in the hospital facilities.

### Baylor Hospital and Medical School

The Baptist Memorial Sanitarium was opened in 1909, being enlarged in 1922 and the name changed to Baylor Hospital. It is the largest sanitarium in the city, having a capacity of 432 beds. One hundred graduate nurses and one hundred and sixty-five training nurses are employed.

The capital invested is in excess of \$3,000,000, the hospital being operated by the Baptist Denominations of Texas.

While the main plant of the Baylor University is located at Waco the schools of Dentistry, Nursing, Medicine and Pharmacy are in Dallas. The enrollment is in the neighborhood of 1000. The Medical Department will be in session during the S. M. A. meeting,, and all its clinics open to visiting physicians.

## ROUTES TO DALLAS

### Atlanta & West Point Railroad Company

The Atlanta & West Point Railroad Company in connection with the Louisville & Nashville and Southern Pacific Lines are arranging to operate thru sleepers from Atlanta, Ga., to Dallas, Tex., by way of New Orleans account of the Southern Medical Association Convention on the following schedule:

Lv. Atlanta. A&WP.....	4:20 PM, Nov. 7
Lv Atlanta. A&WP.....	4:20 PM, Nov. 7
Ar. Montgomery, A&WP.....	9:25 PM, Nov. 7
Lv. Montgomery, L&N.....	9:45 PM, Nov. 7
Ar. New Orleans. L&N.....	7:20 AM, Nov. 8
Lv. New Orleans, Sou Pac.....	12:10 PM, Nov. 8
Ar. Dallas, Sou Pac.....	7:05 AM, Nov. 9

Reduced rates will be authorized on the round trip identification plan which will mean  $1\frac{1}{2}$  fares for the round trip. The rate from Atlanta to Dallas and return will be \$45.27, which is the lowest fare applicable via any route.

### Southern Railway

Special Pullmans for the accommodation of members of the Southern Medical Association will leave Atlanta via Southern Ry., 7:00 a. m., Sunday, Nov. 8th, via Birmingham, Frisco Lines to Memphis, thence Missouri Pacific-Texas Pacific to Dallas. The Special Pullman will be handled from Atlanta to Memphis on the "Kansas City Special" and from Memphis to Dallas on the "Sunshine Special," arriving Dallas 1:15 p. m., Monday, Nov. 9th, in ample time for members to secure hotel accommodations, register, and participate in various entertainments, etc.

Special rate of one and one-half fare for the round trip, on the Identification Certificate plan has been authorized by practically all railroads to Dallas for this meeting and members should secure one of these certificates from Mr. C. P. Loran, Secretary Southern Medical Ass'n, Birmingham, Ala., and when presented to your Ticket Agent will be his authority to sell you round trip ticket to Dallas at rate of one and one-half fare. Tickets on sale Nov. 5th-11th, inclusive, final limit Nov. 18th.

The lower berth rate from Atlanta to Dallas will be \$10.13 and round trip railroad ticket \$45.27.

The return schedule from Dallas will be as follows:

Lv. Dallas via "Sunshine Special" 5:10 p. m., arrive Memphis 6:50 a. m., Leave Memphis via Kansas City Special 8:05 a. m., arrive Atlanta via Southern Railway 8:40 p. m.

Those who desire Pullman reservations in the special Pullman please write Mr. E. E. Barry, D. P. A., Southern Railway, Atlanta, advising what kind of accommodation is desired, and you will be advised promptly what space has been assigned you. Those who may desire to make the trip earlier or later than date of special Pullman may secure accommodations in regular Pullmans on above schedules which are in effect daily.

## District and County Societies

The Secretary of each county society shall report to the Journal of the Medical Association of Georgia full minutes of each meeting and forward to it all scientific

papers and discussions which the society shall consider worthy of publication.—Constitution and By-Laws, Chap. VII, Sec. 15.

### District Editors

1. McGee, H. H., Savannah.
2. Wood, A. W., Albany.
3. Greer, Chas. A., Oglethorpe.
4. Williams, C. O., West Point.
5. Pitts, Jno. B., Atlanta.
6. Hawkins, T. L., Griffin.

7. McCord, M. M., Rome.
8. Carter, D. M., Madison.
9. Bennett, J. C., Jefferson.
10. Lee, F., Lansing, Augusta.
11. Penland, J. E., Waycross.
12. Cheek, O. H., Dublin.

### HONOR ROLL

The following is a list of 100 per cent counties for 1925. The date on which each became a 100 per cent society appears after the name of the society, together with the name of the Secretary:

1. Randolph County, Dr. G. Y. Moore, Cuthbert, December 9, 1924.
2. Dougherty County, Dr. J. A. Redfearn, Albany, December 10, 1924.
3. Pike County, Dr. M. M. Head, Zebulon, December 12, 1924.
4. Hart County, Dr. W. E. McCurry, Hartwell, January 3, 1925.
5. Warren County, Dr. A. W. Davis, Warrenton, January 14, 1925.
6. Monroe County, Dr. W. J. Smith, Juliette, January 14, 1925.
7. Lamar County, Dr. John M. Anderson, Barnesville, March 6, 1925.
8. Upson County, Dr. B. C. Adams, Thomaston, March 30, 1925.
9. Emanuel County, Dr. S. S. Youmans, Oak Park, May 5, 1925.
10. Stephens County, Dr. C. L. Ayers, Toccoa, May 11, 1925.
11. Turner County, Dr. J. H. Baxter, Ashburn, May 12, 1925.
12. Evans County, Dr. D. S. Clanton, Hagan, May 14, 1925.

### EIGHTH DISTRICT MEDICAL ASSOCIATION

The annual meeting of the Eighth District Medical Association was held in Athens, August 12, 1925, in the State College of Agriculture.

The meeting was called to order at ten o'clock by the President, Dr. A. W. Simpson, Washington. Dr. J. C. Wilkinson gave the Invocation. The Address of Welcome was given by Dr. J. C. McKinney, Athens, with Response by Dr. D. M. Carter, Madison. Dr. A. W. Simpson, of Washington, retiring President, delivered the annual ad-

dress. Dr. Stewart D. Brown, of Royston, then gave his report as Councillor of the Eighth District. The following papers were read:

"Studies on the Cause and Treatment of Arterial Hypertension"—Dr. Allen H. Bunce, Atlanta.

"Ectopic Gestation"—Dr. H. M. Fullilove, Athens.

"Tubal Pregnancy: Causes of Errors in Diagnosis with Special Reference to the New Symptoms; Report of ten cases"—Dr. J. Harold Nicholson, Madison.

"Ureteral Stricture: Its Importance to the General Practitioner"—Dr. Jos S. Stewart, Jr., Athens.

"Surgical Treatment of Carcinoma of the Stomach"—Dr. Wm. Perrin Nicholson, Jr., Atlanta.

"Chronic Appendicitis from the Roentgen Standpoint"—Dr. Albert A. Rayle, Athens.

"A Case of Articular Rheumatism Treated with Mercurochrome"—Dr. B. C. Teasley, Hartwell.

"Banti's Disease, Report of a Case"—Drs. H. W. Birdsong, M. A. Hubert and J. O. Wheelchel, Athens.

"Development of the Teeth"—Dr. Linton Gerdine, Athens.

"Some Observations on the Occurrence of Glaucoma"—Dr. W. H. Cabaniss, Athens.

A barbecue was served the visiting doctors on the campus grounds at one o'clock by the Clarke County Medical Society, with Dr. Paul Holliday in charge.

The next meeting of the Association is to be held at Royston at the invitation of Dr. Stewart D. Brown on behalf of Royston and the Franklin County Medical Society.

Dr. H. M. Fullilove, of Athens, was elected President to succeed Dr. A. W. Simpson, of Washington; Dr. B. C. Teasley, of Hartwell, Vice-President to succeed Harold I. Reynolds, and Dr. D. M. Carter, of Madison, was re-elected Secretary-Treasurer.

About fifty doctors were present.



**SECOND DISTRICT MEDICAL SOCIETY**

The summer session of the Second District Medical Society was held in Cairo, Friday, September 12, 1925. The meeting was called to order at nine o'clock. The following scientific program was carried out:

"Thrombosis of the Cavernous Sinus"—Dr. H. M. Moore, Thomasville.

"Some Conditions of the Kidney and Ureters"—Dr. A. G. Little, Valdosta.

"Diagnosis and Treatment of the Acute Abdomen"—Dr. F. K. Boland, President of the Medical Association of Georgia, Atlanta.

"The Relation of the Size of the Heart to Heart Disease, with Reference to Digitalis"—Dr. Stewart R. Roberts, President of the Southern Medical Association, Atlanta.

"Georgia's Crime"—public health address, Dr. J. W. Daniel, Savannah.

A talk on Pediatrics, Dr. L. A. Baker, Tifton. Discussion by Dr. J. A. Redfearn, Albany.

A talk by Dr. J. A. Summerlin, Hartsfield. Discussion by Dr. J. B. Warnell, Cairo.

"The Treatment of Vesical Neck Obstructions by Diathermic Coagulation"—Dr. J. C. Keaton. Discussion by Dr. C. K. Wall, Thomasville.

"Case Reports in the Use of Radium"—Dr. C. K. Wall, Thomasville.

Luncheon was served in picnic style at the new Tourist Park, which was followed by an automobile ride to show the visitors various points of interest.

**FOURTH DISTRICT MEDICAL SOCIETY**

An interesting meeting of the Fourth District Medical Society was held in Carrollton, September 15, 1925. Dr. Hugh McCulloh, of West Point, presided and called the meeting to order at ten o'clock. Rev. J. J. Milford, Carrollton, delivered the Invocation. The Address of Welcome to Carrollton was given by Mayor L. J. Brock. Dr. O. R. Styles, President of Carroll County Medical Society, welcomed the doctors to Carroll County. The Response to the Addresses of Welcome was given by Dr. W. H. Clark, LaGrange. The following papers were presented:

"Indications for Tonsillectomy"—Dr. Claude Griffn, Carrollton. Discussed by Drs. C. A. Peacock, Columbus; M. F. Coch-

ran, Newnan, and W. H. Hadaway, LaGrange.

"Treatment of Fracture of Clavicle"—Dr. R. M. Avery, West Point. Discussed by Drs. Paul Penniston, Newnan; Bert Tillery, Columbus, and G. W. Hammond, Carrollton.

"Myocardial Insufficiencies"—Dr. E. C. Thrash, Atlanta. Discussed by Drs. Emory R. Park, LaGrange, and Allen H. Bunce, Atlanta.

Dr. J. A. Thrash, of Columbus, presented a paper.

"The Mechanical Principles Involved in Surgical Repair of the Downward and Backward Displacement of the Uterus"—Dr. Geo. H. Noble, Atlanta. Discussed by Drs. Hal C. Miller, Atlanta; W. L. Cook, Columbus, and F. M. Ridley, LaGrange.

"Surgical Head Injuries"—Dr. Chas. Dowman, Atlanta. Discussed by Drs. Enoch Callaway, LaGrange; J. A. Johnson, Manchester, and Turner, Newnan.

"Treatment of Pelvic Inflammation"—Dr. B. H. Wagnon, Atlanta. Discussed by Drs. A. A. Barge, Newnan; W. H. Clark, LaGrange, and J. M. Poer, West Point.

"Diagnosis and Treatment of Acute Abdominal Conditions"—Dr. Frank K. Boland, Atlanta, President of the Medical Association of Georgia. Discussed by Drs. F. M. Ridley, LaGrange, and O. W. Roberts, Carrollton.

"Post-Graduate Medicine in Vienna After the War"—Dr. Francis B. Blackmar, Columbus.

"Organization"—Dr. O. W. Roberts, Carrollton. Discussed by Drs. Frank K. Boland, Atlanta, and Allen H. Bunce, Atlanta.

A barbecue dinner was served from twelve to one-thirty.

**NINTH DISTRICT MEDICAL SOCIETY**

We are pleased to report a very interesting and profitable session of our District Society at Toccoa, September 16, 1925. All the essayists were present except Dr. J. P. Bowdoin, but the State Board was represented by Dr. T. F. Abercrombie. Dr. J. H. Downey was also prevented from being on hand to talk radium to us.

The meeting was called to order in the Stephens County Court Room at eleven a.m. by the President, Dr. J. R. Simpson, Gaines-

ville. Rev. Felton Williams, pastor of the Methodist Church, offered the invocation in a sincere, able manner. Dr. C. L. Ayers gave a splendid greeting to us on behalf of the Stephens County Medical Society and a happy response was given by Dr. A. A. Rogers, of Commerce.

The scientific program was one of the best. Dr. F. M. Hubbard opened with his experience on some of his patients with Electro-Therapeutics. Dr. T. F. Abercrombie gave a report on the work of the State Board of Health, recent medical legislation, vital statistics, etc. Dr. W. A. Selman, Atlanta, read a good paper on "Intestinal Obstruction." Dr. Frank K. Boland, Atlanta, our State President, offered a very elaborate discussion on "Abdominal Pain." Dr. L. R. Bryson, Gainesville, read a paper on "The Common Cold." "Sheno-Ganglion Irritation" was discussed by Dr. William M. Fresh, Tooeo. Dr. H. M. Fullilove, Athens, 2nd Vice President of our State organization, offered a very exhaustive discussion of "Renal Calculi," with radiograms. He was assisted by his associate, Dr. Jos. S. Stewart, Jr., Athens.

It was the comment of all, when adjournment was reached, that the day had been well spent. Hon. Fermor Barrett, whose home is at Tooeo, and who was Chairman of the Appropriations Committee of the last General Assembly, appeared before us by request and explained that it was the question of Revenue that held down the appropriations for Health Work in Georgia as well as other matters being supported by the State. He intimated that the Governor might call an extra session of the Legislature and, if he did, we might get in on the ground floor by asking that he include our cause in the call. The Secretary was asked to report this action, which was favorably passed, to the Governor.

The thanks of the Society were extended to our distinguished visitors for their presence and discussions, also, to the Stephens County Medical Society for our splendid entertainment. Dr. Simpson tendered his resignation as President as he is moving to Miami, Florida, in the next few days. He has made an excellent presiding officer and

our best wishes go with him to his new home.

J. C. BENNETT, M.D., Secretary.

### THOMAS COUNTY MEDICAL SOCIETY

Sixteen members of the Thomas County Medical Society were present at the regular meeting held in the nurses' lecture room of the John D. Archbold Memorial Hospital, August 26, 1925.

The meeting was called to order by the President, Dr. S. L. Cheshire, Thomasville, at five o'clock in the afternoon. Dr. C. K. Wall, Thomasville, as Secretary, read the minutes of the last meeting, which were adopted.

Dr. J. T. King, Thomasville, read the first paper of the evening on "Adenoid Tissue, Its Causes, Effects and Treatment." This was discussed by Drs. J. A. Summerlin, Meigs; H. M. Moore, Thomasville, and C. H. Ferguson, Thomasville.

Dr. H. M. Moore, Thomasville, then presented a paper on "Infectious Thrombosis of the Cavernous Sinus," which was discussed by Drs. J. A. Summerlin, Meigs; C. H. Ferguson, Thomasville; J. T. King, Thomasville; A. D. Little, Thomasville, and C. K. Wall, Thomasville.

After the completion of these papers and matters of business were disposed of the members were served a very attractive dinner.

### BARROW COUNTY MEDICAL SOCIETY

The following is a list of the 1925 officers of the Barrow County Medical Society, which was recently sent in to us:

President—Dr. W. T. Randolph, Winder.

Vice-President—Dr. L. W. Hodges, Winder.

Secretary-Treasurer—Dr. W. L. Mathews, Winder.

Board of Censors—Drs. C. W. Almond, E. R. Harris and S. T. Ross, all of Winder.

# Woman's Auxiliary of the Medical Association of Georgia

## Officers

President.	Mrs. William H. Myers, Savannah	Secretary Treasurer	Mrs. A. J. Mooney, Statesboro
Vice-President-at-large.	Mrs. C. W. Roberts, Atlanta	Parliamentarian	Mrs. Allen H. Bunce, Atlanta

### ADDRESS OF PRESIDENT OF WOMAN'S AUXILIARY TO MEDICAL ASSOCIATION OF GEORGIA.

May 14, 1925.

Mrs. James N. Brawner.

A wise man of the East prayed that he "might see today with the eyes of tomorrow." Would that we might have that power today that we might make no mistake in the planning and laying the foundation of this new organization, the Woman's Auxiliary to the Medical Association of Georgia. This is not an organization of our own making. The idea was conceived in the brain of a physician of Texas and through the Woman's Auxiliary that followed in that State, it has spread throughout the country. Our own State Auxiliary came into being at the suggestion and approval of the Medical Association of Georgia in August, May 8, 1924.

In a letter sent recently to the wife of every physician in Georgia, credit was given to Fulton for having been the first county in our State to organize an Auxiliary to a Medical Society. Facts have been brought to light recently which show that the first Woman's Auxiliary in Georgia was organized in the Second District, in 1922, Mrs. Gordon Chason, of Bainbridge, being elected President. I am very glad to make this correction and hope our members from the Second District will understand that the mistake was due to the fact that the State Auxiliary had no record of their organization.

Proof of the sympathetic interest created in the work during our first year is attested by the number of letters received from all parts of the State commending the organization; the pledges of physicians to support

the movement; and the number present at this our first annual convention. The purposes of the organization have been well outlined by the Constitution and by-laws committee. I would like to stress the importance of those aims which look to the advancement of health and education. As Americans we are believers in education—but all education is not book-knowledge. Health education demands a definite study of the laws of health. There are many organizations in our State today, the object of which is to better health conditions, but their opportunities for effective welfare work are not as great as those of an organized body of women such as ours—women who are in a position to know the cause and the remedy for many of the "Ills that flesh is heir to."

Dr. J. W. Daniel, of Savannah, in an address before the Medical Association of Georgia last year said that a man who is sick cannot be an efficient man, and inefficiency is the greatest drawback that Georgia has to face today. With malaria, hookworm and other preventable diseases existing in our midst we who are well and have a well regulated and efficient health department, do not appreciate the disadvantages under which our neighbor in the next country is laboring. It is our duty to see that our neighbor is taught the cause and the remedy for his inefficiency. Until this is done we will never see Georgia at the top of all the Southern States again. Mr. Willis A. Sutton, Superintendent of the Public Schools of Atlanta and President of the Georgia Educational Association, declared in a recent address that "The most fundamental subject in our entire school curriculum is health." "Health education," he said, "is more important than reading, writ-

\*Read before the Woman's Auxiliary to the Medical Association of Georgia, May 15, 1925.



ing and arithmetic, and yet we are devoting only a small part of our time to the development of this subject."

Mr. H. G. Wells, one of the world's greatest writers, said that "for the past century man has busied himself with splendid achievements in a material way, discoveries, inventions, etc. For the next hundred years he shall start a far greater job. Instead of building wonderful machinery, he will try to make wonderful men and women." "After having done marvels with things outside ourselves we are next going to turn our thoughts toward and inside ourselves. We will not bother with trying to change human nature, you cannot change the nature of anything, but there will be ten thousand things that we can do with human nature that has not been done before."

That seems to me to be the broad field for the work of the Woman's Auxiliary. Childhood should be our chief interest—child welfare—especially that phase of it which is peculiarly our own—the development of sound bodies and sound minds. This great field is our own to cultivate. Through the appropriations of the Shepherd-Towner Act, we should see that every prospective mother in Georgia has the proper care, that every child has its divine right to be well born. When we read of the large numbers of babies who die during their first year, owing to the lack of proper care and nourishment; when we learn that 70% of all school children in the State are found to be physically defective; when we are told of the increasing numbers of our children who are going into the mills of Georgia and are deprived of their right to a happy, healthy childhood, is it not time for the intelligent women of the State to awaken to the opportunity that lies before them? Wsise old Paul of Tarsus said "That which ye know and do not, that is sin unto you."

The adoption of the Ellis Health Law in every county would be a forward step in improving such conditions. If the county Auxiliaries would adopt this as their main objective for this year—they would render a service to their community and State that would be invaluable. One of the most hopeful results of the world war was that "It helped us to see ourselves as others see us."

Conditions were brought to light at that time that were calculated to take out of us some of our former spirit of boastfulness. The alarming numbers of those found unfit for service made us realize as never before the urgent need of a real health crusade to produce in our State the type of citizen that we want our boys and girls to be.

Where can better leaders for such a health crusade be found than among the wives of physicians? Women, because of their close touch with the medical profession, better fitted than all others to deal with problems affecting the health and progress of our children. Physicians, as a rule, are too busy carrying on the practice of their profession to give of their time and strength to public welfare or health educational work. It is in giving of ourselves in this broad service that we can best prove our right to the name of helpmate and learn for ourselves the blessings of a better citizenship.

It was with such aims in view that the Auxiliary was organized. Co-operation should form the basis of our work—co-operation with such bodies as the State and County Boards of Health, Women's Clubs, Parent-Teachers' Association and other organizations looking to the betterment of health conditions in the home, the school and the community. In our health campaign, we must not overlook a fight on illiteracy. Ignorance is the greatest enemy of good health, to sanitary living conditions, to the full enjoyment of clean, healthy surroundings that are the right of every boy and girl.

We are not disappointed with results obtained during our first year of organization. The publicity given the movement has created a sympathetic interest among physicians and their wives for real worth-while welfare work. We have probably made many mistakes in our plans and we will probably make more in carrying them out. For all of us to be entirely right in all matters is not humanly possible. We must determine now, each of us, to be a help to the other and bear in mind our duty to our husbands, our children and our community.

In order that the high ideals and aims of the Medical Association may be upheld at all times by the Women's organizations, it would be well to request that each County

Medical Society appoint an Advisory Committee, to whom all activities of the Auxiliaries should be submitted for approval.

There appeared in a recent editorial a severe criticism of our State made by the editor of a newspaper in an Eastern city. It seems to be becoming a habit for the newspapers of the country to "pick" on Georgia. This editor said in part that "the people of Georgia are so sure of the fact that they have the 'best' state in the union, that they are sitting smugly down and letting the rest of the world pass them by." If there is truth in this statement, and there are good reasons for such slurs on our state, it is time that we, as its good citizens, should find the cause for such conditions and do our part in remedying them.

When we have given to every prospective mother in Georgia the care necessary to the safe birth of her baby, and the care to that baby for its proper development; when we have corrected the physical defects of every

child of pre-school age and put thorough medical inspection and efficient follow-up work in every school, when we have rid every community of hookworms, malaria, typhoid and other preventable diseases, we will have done the greatest thing possible in raising the standard of citizenship of our State.

#### Committees.

At the annual State meeting, held in Atlanta, May 13-15, 1925, the following committees were appointed:

Program Committee—Mrs. Gordon Chason, Chairman, Bainbridge; Mrs. J. H. Downey, Gainesville; Mrs. J. A. Redfearn, Albany.

Public Policy and Legislation—Mrs. M. T. Benson, Chairman, Atlanta; Mrs. J. T. Floyd, Atlanta; Mrs. B. H. Wagnon, Atlanta.

Health and Public Instruction—Mrs. Lloyd B. Taylor, Chairman, Savannah; Mrs. J. W. Daniel, Savannah; Mrs. Gordon L. Groover, Jr., Savannah.

## Medical Progress

### Department Editors

Anderson, W. W., Pediatrics  
Ballenger, E. G., Urology  
Bartholomew, R. A., Obstetrics  
Block, E. B., Neurology and Psychiatry  
Clay, Grady E., Ophthalmology  
Dowman, C. E., Neuro-Surgery  
Eques, M. S., Otolaryngology and Rhinology  
Fitts, Jno. B., Internal Medicine  
Greene, E. H., Surgery

Hodgson, F. G., Orthopedics  
Holmes, Walter R., Gynecology and Female Urology  
Jones, Jack W., Dermatology  
Klugh, Geo. F., Clinical Pathology  
Landham, J. W., X-Ray and Radium  
Pruitt, M. C., Proctology  
Thrash, E. C., Internal Medicine  
Waits, C. E., Surgery

### INTRACRANIAL TUMORS

Charles E. Dowman, M.D.,  
Atlanta, Ga.

(Continued from August issue)

**VOMITING:** This is a less frequent symptom than headache. It occurs, however, in most cases of increased intracranial pressure. It frequently occurs when the headaches are most severe. Although occurring in many tumors of the cerebrum, it is a particularly early symptom in tumors located below the tentorium. The vomiting is independent of eating and is not necessarily preceded by nausea. The so-called "projectile" vomiting is a very characteristic symptom of increased intracranial pressure. When intracranial pressure is materially increased the medulla may be forced down into the foramen mag-

num, thus causing an upset of the vagus centers, vomiting being a natural result.

**PAPILLEDEMA** (choked discs): A swelling of the optic nerve head practically always occurs when there is marked chronic increase of intracranial pressure. The mechanism of papilledema has been the source of much argument among neurologists and ophthalmologists. It is probably caused by cerebrospinal fluid being forced down the vaginal sheath of the optic nerve. The space within this sheath communicates directly with the subarachnoid space. When the fluid within the interpeduncular cistern becomes excessive and under increased pressure the vaginal sheath of the optic nerves become distended and the nerve head becomes swollen. Such a swelling of the optic discs interferes with the venous circulation of the optic nerve. On

account of this obstruction to the return venous flow the retinal veins become engorged and tortuous and at times actual hemorrhages in and around the swollen discs may occur. Should the process continue there eventually occurs an organization of the albuminous fluid in the vaginal sheath and in the nerve head, which in turn constricts the nerve fibers. This terminates eventually in a definite gray atrophy of the discs, an atrophy which is usually spoken of as consecutive or secondary optic atrophy. As the examination of the eye grounds is so important in diagnosing chronic increased intracranial pressure the use of the ophthalmoscope should be as familiar to physicians as is the use of the stethoscope. Since the advent of the electrically lighted ophthalmoscope this most important examining instrument has been so simplified as to make it possible for anyone to study carefully the optic discs and the surrounding retina. A slight amount of practice will soon teach one to detect a normal from an abnormal disc.

If we accept the above mentioned mechanical theory of the causation of choked discs the term "optic neuritis" should not be used to designate this important finding of increased intracranial pressure. A true optic neuritis presupposes an inflammation of the optic nerve fibers, and is a condition which is always accompanied by a rapid diminution of visual acuity. In true choked discs, on the other hand, the visual acuity is not effected until late in the process, when secondary atrophic changes take place. It is highly important, therefore, to diagnose an increased intracranial pressure before the onset of these atrophic changes, as otherwise the patient's sight may be permanently damaged before the intracranial condition receives proper treatment. The early detection of a papilledema is therefore of paramount importance and the responsibility falls rightfully on the general practitioner, as the patient will not consult an ophthalmologist until the sight is impaired. When the visual acuity has been effected a completed restoration of sight is usually impossible. When a patient with tumor of the brain becomes totally blind the eyesight does not return even though the tumor can be removed at operation. The exception to this rule is the loss of sight which

sometimes occurs in pituitary tumors. In this latter condition the mechanism has been an entirely different one, as there has been direct pressure by the tumor on the optic chiasm. A relief of this pressure will cause an immediate restoration of sight unless there has already occurred a complete primary optic atrophy.

The symptoms and findings which have just been discussed are usually termed the three "cardinal symptoms" of the chronic increase of intracranial pressure. When present one is justified in presuming that there is an intracranial tumor of some type. It is not necessary for all three of these symptoms to occur in cases of brain tumor and fortunately there may be other symptoms and findings which may lead one to suspect an intracranial tumor before the onset of these general pressure symptoms.

**MENTAL DULLNESS:** This condition is probably the result of the persistent headaches which are in turn due to the increased pressure. As the intracranial pressure increases there is a tendency for the patient to become drowsy, inattentive, apathetic, slow to answer questions, and indifferent to the ordinary interests of life. Such mental changes have no particular localizing significance unless they develop independent of some of the other symptoms of increased pressure. In the absence of these other symptoms such mental changes may indicate a tumor located in the prefrontal region.

**CONVULSIONS:** It is surprising how many cases of tumor of the brain give a history of having had generalized epileptiform convulsions. These attacks may occur in cases of tumor located in almost any part of the brain. The tumor may not be located near the motor areas or pathways even though the convulsions be attended by motor manifestations. They may occur as the initial symptom of brain tumor, or, on the other hand, they may not occur until the condition is well advanced. They are probably due to the greatly increased intracranial pressure. When occurring as an initial symptom of brain tumor the case is usually diagnosed as one of idiopathic epilepsy and the true condition may not be suspected until other convincing symptoms become manifest. Such generalized convulsions have no localizing



value unless preceded by so-called Jacksonian phenomena. Epileptiform attacks are so frequent in cases of brain tumor that their occurrence, particularly when they begin in adult life, should always cause one to think of intracranial tumor as a possible cause.

**DIZZINESS:** This is not infrequent symptom of brain tumor. When accompanied by definite signs of inco-ordination, the symptom may have localizing value. On the other hand, the increase of intracranial pressure may upset to a certain extent the vestibulo cerebellar mechanism, thus giving rise to attacks of vertigo. When accompanied by other symptoms of increased pressure dizziness may be present in cases of tumor located in various portions of the brain.

**DIPLOPIA:** Double vision is a very frequent symptom of increased intracranial pressure and as a rule does not have any localizing significance. When present it is usually due to a paresis of one or both 6th cranial nerves. As these nerves supply the external recti muscles of the eyes a disturbance of one or both of them will cause a loss of parallelism of the eyes. It so happens that these nerves have a very long course within the cranial cavity and can be readily disturbed when the intracranial pressure is increased. In their course they cross under one of the branches of the basilar artery and it is argued by some that in the presence of increased intracranial pressure there is direct pressure on the nerves by the arteries. Whatever the explanation is, the fact remains that transient or permanent diplopia is a characteristic phenomenon of increased intracranial pressure.

Although bradycardia (slow pulse) is frequently mentioned in various text-books as a sign of increased intracranial pressure, this symptom is so variable in chronic cases that I have not mentioned it in this connection. It is quite true that when the medulla is forced down into the foramen magnum as the result of increased intracranial pressure the cardioinhibitory and respiratory centers may be so disturbed as to cause a slowing of the pulse and a marked decrease in the respiratory rate. On the other hand there are many cases of intracranial tumor in which there is a tachycardia.

The so-called "localizing" symptoms of intracranial tumor are sometimes entirely absent even when one is thoroughly convinced that an intracranial tumor is present. In most cases, however, there are sufficient localizing symptoms and findings to enable one to fairly accurately determine the location of the tumor. These symptoms and findings will be discussed in another lecture when we will consider the symptomatology of tumors in various parts of the brain. Occasionally the roentgen ray will disclose an abnormal shadow which is of localizing value. Such shadows, however, do not occur unless there happens to be calcium infiltration within the tumor. When a systematic neurological examination fails to locate the lesion one may have recourse to a method described by Dandy in which air is injected into the lateral ventricles. Air casts a shadow on the roentgen film, a fact which may enable one to determine whether or not there is an internal hydrocephalus, a collapsed ventricle, an obstruction of the interventricular foramina, a filling defect of portions of the ventricles due to a neighboring tumor, etc. By using this method it is sometimes possible to locate an intracranial tumor which a careful systematic neurological examination fails to reveal. The method of air injection should be reserved for those cases in which all other methods of examination have failed to give localizing evidence. It is not a method which is entirely lacking in danger. Recently Grant, of Philadelphia, gathered the statistics of twenty-two neurological surgeons who had had experience with this method. From these statistics the mortality rate was something over nine per cent.

(To be continued.)

---

## NEWS ITEMS

Dr. F. A. Vogt, formerly associated with Dr. F. M. Sutton at 65 Forrest Avenue, Atlanta, is now practicing in Miami, Florida. He was graduated from Emory University School of Medicine in the class of 1919 and is a member of the Fulton County Medical Society. Dr. Vogt's numerous friends are wishing him continued success in his new location.

Dr. J. A. Summerlin has removed from Hartsfield, where he was President and Delegate of the Colquitt County Medical Society, to Pelham, Mitchell County.

Dr. Ford Ware has returned to his home in Cordele after having spent July and August in Brooklyn, New York, doing "loeu menteneus" practice for Dr. J. H. Andrew, who is a prominent eye surgeon in Brooklyn. While in New York Dr. Ware also did post-graduate work in the Brooklyn Eye and Ear Hospital, where he was formerly house surgeon.

Dr. John S. Derr announces the installation of a high voltage equipment for deep x-ray therapy in his offices in the Hurt Building, Atlanta.

Dr. Arch C. Cree, Superintendent of the Georgia Baptist Hospital, Atlanta, has returned from an extensive tour of Palestine, Syria, Egypt and Europe. Immediately upon his return Dr. Cree took up his plans for a Greater Georgia Baptist Hospital. A campaign to raise funds for doubling the size of the present institution at a cost of five hundred thousand dollars was begun the first of October.

Dr. N. R. Thomas, after practicing in Milledgeville for eight years, is being welcomed as a new member of the medical profession in Albany. Dr. Thomas has offices in the Exchange National Bank Building.

Dr. Harold F. McDuffie is now associated with Dr. G. D. Ayer, Hurt Building, Atlanta, in the medical and surgical treatment of diseases of the eye, ear, nose and throat. Office hours from nine a. m. to one p. m. and four p. m. to 6 p. m.

The friends of Dr. D. M. Bradley, of Waycross, are sympathizing with him on the recent death of his father, Mr. D. M. Bradley, of Hagan. Mr. Bradley's death was caused from injuries received in an automobile accident.

Have you read the leading editorial in this month's Journal? The doctors, dentists, Cartersville Rotarians and citizens all cooperated in examining 763 children in two days. Doctors and dentists gave their ser-

vices free of charge; Rotarians furnished what money was needed; firms made donations of ice, electric fans, beds, mattresses, etc., and ladies furnished sheets, pillow cases and towels which were afterwards laundered without charge. The Association is proud to claim as members such men as the members of the Bartow County Medical Society.

Dr. E. E. Martin has removed from Waycross, where he was a member of the Ware County Medical Society, to High Springs, Florida. Dr. Martin's hosts of friends sincerely regret his departure.

Dr. R. A. Bartholomew, with offices at 20 Ponce de Leon Avenue, Atlanta, announces that in the future his practice will be limited to obstetrics.

Dr. D. G. Elder is planning to erect a modern sanatorium at his home in Chicamauga so as to take care of the patients in and around Walker County.

Dr. J. M. Anderson, of Barnesville, has been appointed a member of the State Board of Medical Examiners by Governor Walker for a term of four years. Dr. Anderson is the efficient Secretary-Treasurer of Sumter County Society.

Dr. W. B. Jameson has opened offices in the Lamar Building, Augusta, to limit his practice to diseases of infants and children. Dr. Jameson is a graduate of the Medical Department of the University of Georgia and is on the staff of the pediatric department of the University.

Dr. H. J. Peavy is now located in Miami, Fla., where he has entered the real estate business. He is a member of the Bibb County Medical Society, having formerly resided in Macon.

Dr. W. M. Scott is being welcomed in Milledgeville, where he is practicing medicine and surgery. He was formerly of Devereaux. Dr. Scott has purchased the office equipment and good will of Dr. N. R. Thomas, who has removed to Albany.

The Idaho State Medical Association held its thirty-third annual session at Pocatello, September 3, 4 and 5, 1925.

## COMMUNICATIONS

### To the Editor:

I notice in the August issue of the Journal, just received, that the Chairman of the Committee on Public Policy and Legislation has appointed a subcommittee to make his Committee more efficient.

That may not be a violation of the letter of the law but it certainly is of the spirit of the law. In the By-Laws of County Societies, Chapter IV, Sections 1 and 4, there is provision for a standing committee on Public Health and Legislation and that this Committee work in conjunction with the Committee of the State Association in all matters pertaining to legislation, etc.

These Committees from the several county societies should be the ones to work with the Chairman and should not be ignored but should be encouraged to take an active part in all such matters. By helping the county societies to properly function and take more active interest in such matters, much more effective work can be done.

M. A. CLARK, Parliamentarian.

### To the Editor:

Will you please call to the attention of the members of your Society the following resolutions passed by the State Board of Health, which are self-explanatory.

"A resolution was carried directing the Secretary to address a communication to the County Medical Societies in the State of Georgia, calling their attention to the large number of specimens submitted to the State Laboratory for examination and to the burden this places upon our appropriation, and request that the physicians who are members of the aforesaid societies cooperate with the State Board of Health to the extent that where they have patients who are able to pay for this service that they either send their specimens to local laboratories or to some physician who is doing private laboratory work."

"Further, that the State Board of Health is not a competitive agency, and does not wish to compete with local laboratories, but is willing to do this work for charity patients."

Sincerely yours,  
T. F. ABERCROMBIE, M.D.,  
Commissioner of Health.

## ERGOT FOR HYPODERMIC USE

Some of our most valuable drugs are dependent entirely upon the pharmaceutical manufacturer for their reliability. Take ergot as an example. It is not to be expected that all natural specimens will contain the same percentage of active principle, and experience has proved that they do not. The necessity of standardizing ergot preparations has long been apparent, but chemical methods were not available because of the complexity of the active principles. Once it was thought that ergotinic acid was the active principle, but now the less of this an ergot preparation contains the higher it is rated, other things being equal. The alkaloid ergotoxin is very important, but certain amounts of the amines, histamine and tyramine, must also be present.

Since, however, ergot has long been used in medicine for its effect upon the involuntary muscles, the idea occurred to Dr. Houghton, of Detroit, in 1895, that an ergot preparation might be tested by administering it to cocks and observing its effect upon the comb, the degree of bluing or blackening produced being taken as an indication of the physiologic action of the specimen. In 1898 this method was adopted by Parke, Davis & Co. as a standard method for assaying their commercial products of the drug. It is now generally recognized as the most practicable method of assay known.

It is sometimes desirable to administer ergot hypodermically, but the ordinary fluid extracts are not suitable for this purpose. To give a small dose double efficiency, a preparation is now available called Ergot Aseptic, each cubic centimeter of which is equivalent to two cubic centimeters of the official fluid extract. Further particulars are given in the Parke, Davis & Co, advertisement elsewhere in this issue.

## EFFECT OF PERTUSSIS ON THE HEART

Analysis of 232 cases of pertussis as to its effect on the heart has convinced Paul V. Ledbetter, Houston, Texas, and Paul D. White, Boston (Journal A. M. A., April 4, 1925), that there is no proof of endocardial or myocardial damage during or after pertussis. Circulatory failure does not seem to occur during pertussis, though the paroxysms of whooping cough undoubtedly do produce a temporary mechanical strain, particularly on the right side of the heart. No evidence of damage to the heart in any case, as a result of whooping cough, could be found in these 232 cases, although one child had chronic endocarditis and one had congenital heart disease before infection.



# Proceedings of The Seventy-Sixth Annual Meeting of Medical Association of Georgia

## Atlanta, May 13, 14 and 15, 1925

(Continued from September issue, page 398)

THURSDAY, MAY 14, 1925

### THIRD MEETING

The House of Delegates was called to order at 8:15 A. M. by the President, Dr. J. O. Elrod, Forsyth.

#### ROLL CALL:

The Secretary requested each member to turn in card containing his name and the County Society he represented, or other credentials, and the following gentlemen responded:

Dr. C. E. Waits, Fulton County.  
 Dr. C. L. Ayers, Stephens County.  
 Dr. L. A. Baker, Tift County.  
 Dr. Stewart D. Brown, Franklin County.  
 Dr. J. R. Burdett, Washington County.  
 Dr. J. L. Campbell, Fulton County.  
 Dr. M. A. Clark, Macon (Parliamentarian).  
 Dr. T. H. Clark, Coffee County.  
 Dr. E. B. Claxton, Laurens County.  
 Dr. Warren A. Coleman, Ocmulgee County.  
 Dr. A. S. M. Coleman, Douglas (Councillor 11th District).

Dr. T. C. Davison, Fulton County.  
 Dr. J. G. Dean, Terrell County.  
 Dr. G. L. Echols, Baldwin County.  
 Dr. H. L. Erwin, Whitfield County.  
 Dr. Howard T. Exley, Chatham County.  
 Dr. R. C. Franklin, Emanuel County.  
 Dr. Ralph Freeman, Jackson County.  
 Dr. J. L. Garrard, Floyd County.  
 Dr. C. B. Greer, Glynn County.  
 Dr. J. H. Grubbs, Pike County.  
 Dr. C. A. Harris, Upson County.  
 Dr. V. O. Harvard, Crisp County (Councillor 3rd District).

Dr. M. M. Head, Zebulon (Councillor 6th District).

Dr. Z. V. Johnston, Gordon County.  
 Dr. L. F. Lanier, Screven County.  
 Dr. Thos. J. McArthur, Crisp County.  
 Dr. R. L. Miller, Burke County.  
 Dr. Cliff Moore, Floyd County.  
 Dr. J. W. Palmer, Ailey, Ex-President.  
 Dr. W. E. Person, Fulton County.  
 Dr. J. L. Porter, Morgan County.  
 Dr. A. A. Rayle, Clarke County.  
 Dr. W. F. Reavis, Ware County.  
 Dr. C. H. Richardson, Jr., Bibb County.  
 Dr. C. T. Ridley, Bibb County.  
 Dr. C. W. Roberts, Chairman, Com. Public Policy and Legislation.

Dr. O. W. Roberts, Carrollton (Councillor 4th District).

Dr. W. A. Selman, Fulton County.  
 Dr. A. W. Simpson, Wilkes County.  
 Dr. A. C. Smith, Elbert County.  
 Dr. C. W. Strickler, Fulton County.  
 Dr. J. A. Summerlin, Colquitt County.  
 Dr. B. C. Teasley, Hart County.  
 Dr. C. Thompson, Millen (Vice-Councillor 1st District).

Dr. E. C. Thrash, Atlanta, Ex-President.  
 Dr. B. H. Wagnon, Fulton County.  
 Dr. A. J. Waring, Chatham County.  
 Dr. Robert F. Wheat, Decatur County.  
 Dr. C. D. Wheelchel, Gainesville (Councillor 9th District).

Dr. L. L. Whiddon, Irwin County.  
 Dr. C. H. Willis, Lamar County.

The President announced that he had appointed Dr. Stewart D. Brown of Royston as Delegate from Franklin County.

#### MINUTES:

On motion duly seconded and carried the reading of minutes was dispensed with.

#### REPORT OF COMMITTEES:

*Committee on Public Policy and Legislation:* Dr. C. W. Roberts, Chairman, presented the following revised report:

Dr. Roberts: Your Committee, who attempted to report at the opening meeting of the House neglected to make certain explanations which may be in order before proceeding with the supplementary report.

The Committee made an attempt to sponsor certain measures which had been referred to the Committee at the action of the House of Delegates at the Augusta meeting. The first part of our report pertained to that and was, briefly, a report that no bill which was sponsored by the Committee was introduced and nothing was done. The matters which were referred to this Committee at Augusta were taken up and put into bills and presented to members of the House and we undertook to persuade them to introduce the bills, but nothing was done. Nothing whatever was accomplished. I made certain deductions from our failures and those deductions were as follows: (Read first portion of report.)

I must make another explanation at this point. Your Committee under its activities during the past year was laboring under the definite statement made to us that the Committee had been appointed for a three-year term, and in view of the fact that we had one Legislature convening during that period we thought it wise to formulate a program which

would take care of the needed legislation for this Association during the two-year period. If there is need of an apology for offering a long, conclusive and elaborate report by those who worked I would offer this excuse for the long report. It developed since this meeting that the efforts of the Committee are to be over with this session and it would be presumptuous of your Committee to undertake to do anything of the kind.

There was a called meeting of the Committee yesterday afternoon which was attended by Dr. McCurry and Dr. Clark, an added member of the Committee.

The second meeting which was called during the past year was one called on April 14, 1925. Your Chairman takes the responsibility for the conception of the idea that it would be well to call into council certain men who are not members of the Committee on Public Policy and Legislation, because we proposed at that meeting on April 14th to present a concrete program. We invited to meet with us as counsellors a certain number of men, Dr. J. O. Elrod, Dr. Allen H. Bunce, Dr. J. W. Palmer, Dr. T. F. Abererombie, Dr. John W. Daniel, Dr. C. T. Nolan, Dr. Theodore Toepel, Dr. C. E. Waits. These men were requested to meet with us as advisors because we desired to marshal all the support we could for any program which we recommended to this House of Delegates, and because we felt the need of help, which we believed these men could give us. When we met the statement was made that a program which was to be the recommendation to the House of Delegates at this time had been prepared and upon motion that report was read. I wish the privilege of again reading the report which was presented at that time: (Read report.) This report was first read in full and then in sections and was unanimously approved by the two members of the Committee and the others who were present. Dr. J. O. Elrod had to leave to attend a meeting of the Council in Macon but spent the morning going over the matter with me. (Then read paragraphs 1st, 2nd and 3rd.) In explanation of this, it means that we devise ways and means whereby as soon as any bill is introduced which affects the doctors and the people of Georgia in a public health way this information and the contents of the bill shall be sent to the doctors over the State, such information to be sent every ten days during the meeting of the Legislature, in an effort to arouse their interest in the support or defeat of the bills. This was also approved at that meeting. (Then read paragraph 4th.) A word of explanation: at the conclusion of the meeting of this Association

in Savannah two years ago, on the recommendation of Dr. Hardman, I think, of Commerce, such a recommendation was made and such a Commission was appointed by the outgoing President, Dr. Smith, but for some reason that Commission died at that time and nothing was ever heard of it. The purpose of such a Commission is simply to collect facts bearing upon the efficiency of the industrial records in the State of Georgia, since it is known that everyone agrees that this State needs industrial development. The manufacturers and others who have investigated the conditions in Georgia have found a lack of efficiency in industrial endeavor in Georgia. Therefore, we believe that such a special commission, bearing on that particular feature, would be of value to the citizens of our State, and this portion of the report was also approved. (Then read paragraphs 5th, 6th, 7th and 8th.)

A meeting was held yesterday which was attended by your Chairman, Dr. Clark, and Dr. McCurry. We reviewed the report which I have read in sections and agreed that it might be gone over just as it was written as the report of the Committee. We also took up the question of the lobbying matter and Dr. Clark brought to my attention the fact that some motion had been made before the House of Delegates asking for authority to employ a counsellor and for a certain amount of money to be appropriated to aid the Committee in the accomplishment of the work which it had set out to do. It was asked that that motion be put as to whether we as a Committee would accept that tendered aid in the way of a counsellor.

Dr. Miller: I move that the report be adopted as Dr. Roberts has presented it.

Motion seconded by Dr. Clark and unanimously carried.

#### NEW BUSINESS:

The President: Is there anything to come up under the head of new business, gentlemen?

Dr. J. L. Campbell: I understand there was a question of allowing Dr. Harris to present some of his work on cancer at one of our sessions, and I wish to state that this request was inspired by Dr. Abererombie. I asked Dr. Harris if he would be willing to present some of his work if I could get him an opportunity to do so and he said he would. I just wished to explain that the request had not come from Dr. Harris, but from me, and that it was instigated by Dr. Abererombie. Dr. Harris has done some splendid work in a few cases and I thought it might be well to allow him to present it before the Association.



*Report of Council:* Dr. V. O. Harvard, Chairman, presented the following report:

In the appeal of Dr. J. E. Woods of Jackson, Georgia, from the action of the Butts County Medical Society, your Council beg to report as follows:

In executive session with the Councillors, President, Secretary and Parliamentarian present, Dr. Woods was given opportunity to present his case fully and freely, and allowed to answer questions asked by different members of the Council, thereby giving a full and clear understanding of his claims and his attitude toward the Society.

Dr. A. F. White, for the Society, made a statement of their position and their reasons for the action of the Society. No other members were present and after an opportunity for rebuttal by Dr. Woods and Dr. White, they were retired and the Council gave due consideration to the evidence submitted, and appointed a committee of three, Councillor Head, President Elrod and Parliamentarian Clark, to interview Drs. Woods and White and ascertain which compromise might be possible, and report back to the Council at the next meeting.

This Committee reported that after a very plain but friendly talk with all parties they became more conciliatory and gave evidence of a probable reconciliation.

Your Council find that the Society in refusing to accept the check of Dr. Woods in July, 1919, in payment of dues for that year, and advising him that he must make application as a new member, was in violation of the By-Laws, Chapter 5, Section one: "A member suspended for non-payment of dues shall be restored to full membership on payment of all indebtedness."

Dr. Woods in not paying dues for 1920, '21 and since that time was in violation of the Section, "Members more than one year in arrears shall be dropped from the roll of members," and therefore in order to become a member Dr. Woods must make application in the manner in which any new physician may apply. The manner of giving testimony and the feeling manifested showed much evidence of the frailty of human nature on both sides.

Your Council recommended that Dr. Woods make application in due form and express to the Board of Censors of the Butts County Medical Society his regrets that mistakes have been made, and his full assurance that he will co-operate with and do all within his power to become a useful and efficient member.

After Dr. Woods has done this the Society is urged to accept him in full membership and, forgetting the past, to all work for the good of the Society and each other.

Dr. Head, Dr. Clark and the new President are to visit the Society and report this action of the Council, and do all within their power to bring about this much desired reconciliation.

Dr. Clark: In order to carry out the By-Laws any appeal must go to the Council and after that is done the House of Delegates can ratify the action of the Council.

Dr. Miller: I move that the House of Delegates ratify the report of the Council.

Motion seconded and unanimously carried.

The President: Gentlemen, is there anything further to be considered at this time?

Dr. L. G. Hardman: I have a resolution which I would like to present, as follows:

To the Medical Association of Georgia:

Whereas, we are informed that there is a movement to erect a suitable building for educational purposes on the campus of Martin Institute at Jefferson, Georgia, as a memorial to the life and services of Dr. Crawford W. Long, and

Whereas, it was at Jefferson, Georgia, that sulphuric ether anesthesia was first discovered by the said Dr. Crawford W. Long, March 30, 1842, therefore

Be it Resolved, by the Medical Association of Georgia, in annual convention assembled, that we give our hearty endorsement to the project and assure the promoters of our support and best wishes.

Dr. Hardman: This resolution was presented to the Jackson County Medical Society and has been signed by every doctor in that District and also by the President of the Ninth District Medical Society. This gives you an idea of the opinion of the medical men in that section regarding the erection of such a memorial to Dr. Crawford W. Long. We ask for your approval and the adoption of the resolution. It does not obligate you financially or in any other way. As you are already aware, there now exists there a monument to Dr. Crawford W. Long which was unveiled some years ago, and it is the wish of the profession that such a building be erected.

(No action was taken.)

Dr. R. L. Miller: Mr. President, I wish to bring up the subject of the Georgia Children's Code Commission. They have prepared a Code and I wish to read just a brief resume of it, it is very short.

To His Excellency, the Governor,  
and the General Assembly of Georgia:

The undersigned members of the Georgia Children's Code Commission submit herewith for your consideration a code of eight laws in which are gathered, codified and improved the laws affecting dependent, delinquent, neglected and defective children. This report is



the product of two years' careful study under the direction of your Commission and is in compliance with the Act of the Legislature of 1921, creating this Commission and instructing it to study, improve and revise the laws affecting children.

The bills have been submitted to all those groups which they affect and have the endorsement of them all. They are also supported by the Federation of Women's Clubs, the Parent-Teacher Association, the League of Women Voters, the Georgia Education Association and many other organizations.

When it is considered that these laws were in most instances antiquated and sadly in need of revision, we bespeak your earnest consideration of them in behalf of Georgia children. Their passage will insure the rights of scores of innocent children who are now silent sufferers.

This work has been done at no expense to the State, all funds having been supplied from private sources interested in child welfare.

Respectfully submitted,

Mrs. Alonzo Richardson, Chairman (representing State Dept. of Public Welfare).

Dr. W. L. Funkhouser, Atlanta, Secretary (representing State Dept. of Health).

George H. Carswell, Irwinton (representing State Senate).

Mrs. Viola Ross Napier, Macon (representing House of Representatives).

Judge R. Eve, Tifton (representing Superior Courts).

Mrs. E. R. Hines, Milledgeville (representing State Federation of Women's Clubs).

Mrs. Albert Foster, Madison (representing State League of Women Voters).

J. C. Logan, Atlanta (representing State Council of Social Agencies).

Emmett Quinn, Atlanta (representing State Federation of Labor).

J. W. Simmons, Atlanta (representing State Dept. of Education).

Burr Blackburn, Executive Secretary.

### **PRINCIPAL CHANGES SOUGHT IN PROPOSED LAWS**

*NOTE.—We have here reprinted only the introduction of the Commission's report. The entire report with full text of laws has been published and will be supplied on request.*

Underlying the series of eight laws presented is the principal of establishing the Juvenile Court as the children's court in which is concentrated, as far as constitutionally possible, all judicial action for the protection of handicapped children, and connecting the system up with all child-caring agencies through the State Welfare Department, thus affording a unified State-wide program for the protection of child life—the prevention

of adult criminality and dependency.

Advanced States have long since adopted this plan. It rests for its efficiency upon trained, capable probation officers, upon whom most of the work of adjusting children's difficulties naturally falls. As long as jurisdiction over children is divided among many courts it will be impossible to develop painstaking probation service. Hence we feel that the two most important features of this code of laws is the establishment of a non-political method of examination and selection of probation officers and widening the jurisdiction of the Juvenile Court to include controversies over custody of children, adoption, desertion, illegitimacy, compulsory attendance, child labor, feeble-minded children, cruelty to children and kindred offenses.

Following is a resume of the bills:

#### **1. Juvenile Court Bill**

Making present law constitutional.

Keeping children out of jail.

Giving the court jurisdiction over adults who contribute to the delinquency or neglect of children.

Taking the appointment of judges out of politics.

Providing examination and certification of probation officers.

Protecting the interests of children when their custody is transferred.

Providing a court in every county.

Providing for supervision of children paroled from institutions.

#### **2. Non-Support and Desertion**

To enforce parental support and maintenance of children.

To provide for the support of children when a parent is imprisoned. (This bill is taken from the law drawn by the National Commission on Uniform State Laws and is in effect in over half the States. Georgia has no such law except a very ineffective abandonment law.)

#### **3. Legal Adoption Law**

To change jurisdiction in adoption proceedings in cases of children under 16 years of age from the Superior to the Juvenile Court.

To more definitely prescribe the conditions under which adoption is permitted.

To provide a careful social investigation by the State Welfare Department or a licensed child placing agency before adoption is granted in order that the child's interests may be protected.

#### **4. Illegitimacy Law**

To provide for the establishment of paternity of a child born out of wedlock.

To enforce parental support of such a child.

To place jurisdiction in penal and civil cases in the Juvenile Court. (This is also one of the laws prepared by the Commission

on Uniform State Laws and is in effect in many States. Georgia's bastardy law is over 100 years old, is brutal and inhuman and has been abandoned by all civilized peoples.)

### 5. Child Labor Law

To eliminate exemptions of children—permitting no child to work under 14 years of age in occupations covered by the present law.

To provide a modern system of certification of children 14 to 16 years of age who go to work, thus adopting the only possible method of enforcing a child labor law.

To prohibit night labor in the same occupations by children under 16 years of age and the same system of certification for children 16 to 18 who enter night work.

(This law has the endorsement of the Cotton Manufacturers Association. It is not ideal as the Commission would desire, as it does not extend the law to cover other occupations, provides no regulation of hours of labor and no physical examinations. The Commission submits this as the minimum which should be passed, as it feels that Georgia must this year show the world that she is interested in protecting her children. If other bills are to be presented and the Legislature should accept one that is more advanced we will heartily approve. We believe that it will require some years to secure the ideal child labor laws in existence in other States, as we have made no changes in our laws for twenty years, while other States have been making steady improvement.)

### 6. Compulsory Attendance Law

To extend the law to cover the seventh year (7 to 14 years).

To place jurisdiction in the Juvenile Court and eliminate red tape in the present law.

To make the law cover all schools, public and private, and to provide against many evasions possible under the present law.

To give the State Department of Education duties in seeing that the law is enforced.

To provide for children 14 to 16 to attend school if they are not employed.

To provide a uniform system of reporting absences and removals.

### 7 and 8. Laws Governing the Boys' and Girls' Training Schools

There are no important changes in these laws. The wording is revised to eliminate harsh prison terms and to emphasize the reformative nature of the institutions. Annual election of officers by the boards is provided. The present practice of caring only for white girls at the Girls' Training School is made legal. It is our hope that a separate institution for colored girls may be established at an early date.

Dr. Miller: I move the adoption of this Code.

Motion seconded and carried.

The President: I wish to state that I was responsible for appointing the Committee on Public Policy and Legislation. I appointed the Committee with the understanding that the members were appointed for three years, but upon looking into the report of the House of Delegates I found that the Committee was for one year only. The rule was adopted by the House of Delegates at the meeting on May 13, 1925, and the members of the Committee are now appointed for three years. Is there anything further, gentlemen?

Dr. T. G. McArthur: I wish to present the following resolution, Mr. President:

Whereas, at the next session of the General Assembly of Georgia there will be presented a bill authorizing a Seventy Million Dollar bond issue for paving the roads of the State, and,

Whereas, paving roads by this method will not only prove to be more economical but will also be a great advertisement for our State; therefore,

Be it Resolved, by the Medical Association of Georgia, that we most heartily approve such bill.

I move the adoption of this resolution.

Motion seconded.

Dr. Miller: I think it is a question, Mr. President, whether it is the proper thing for the Association as a scientific body to go into such a question as this. I am in favor of good roads and of the bond issue, but I think the Medical Association of Georgia should not take part in this thing. I move that the motion be tabled.

Motion seconded and upon rising vote was lost.

Dr. Clark: I wish to speak simply as a member of the House of Delegates and to ask a question. Does your passing this resolution pledge the members of the Association to the support of this bill? After thorough investigation of the matter I may be heartily in support of it. I am in favor of good roads but do not wish to pledge myself to any bill which may bring up a matter of taxation in the future. I think doctors do not help themselves as doctors by getting into politics. It is all right for them to endorse good roads individually, but as the business portion of the Medical Association of Georgia I think we should let politics alone.

This question was further discussed by Drs. McArthur, Thrash, Miller, Greer, and Waring, following which Dr. McArthur's motion to adopt the resolution approving the bill was put to a rising vote and carried by twenty-three to eighteen.



The President: Is there anything further, gentlemen? You know this is the last meeting of the House of Delegates.

Dr. Thrash: I have a resolution relating to the work of the State Board of Health which I would like to present, as follows:

**RESOLUTION COMMENDING THE  
WORK OF AND PLEDGING SUP-  
PORT TO THE STATE  
BOARD OF HEALTH**

I

Whereas, the Georgia State Board of Health, under the able leadership of Dr. T. F. Abercrombie, is rendering invaluable service to the citizens of the State of Georgia through its work in the prevention of all diseases, thereby enriching the state from a material and physical standpoint, and

Whereas, the State Board of Health is greatly handicapped by the lack of funds to carry on its absolutely essential activities,

**BE IT RESOLVED**, That the Medical Association of Georgia in convention assembled representing the physicians of the entire state, pledge its loyal and active support to whatever measures may be decided upon to relieve the financial distress of the Board of Health.

II

Whereas, the conference on Venereal Disease Control Officers of the State Health Departments and the U. S. P. H. S., held at Hot Springs, Ark., December 1, 2, 3, 1924, adopted the following policy: "That no clinic supported by Federal or State tax funds, in whole or in part, should treat patients who are able to pay," and

Whereas, members of the association have spent a great deal of time and money in equipping themselves and equipping private offices and laboratories throughout the state for the purpose of making all necessary examinations, and

Whereas, at present the laboratory of the State Board of Health, supported by public funds, is in direct competition with members of this association, since it makes no discrimination or inquiry as to whether examinations are for charity patients, therefore,

**BE IT RESOLVED**, That we petition the State Board of Health that it have printed or stamped on its information blank the statement: "This patient is unable to pay for the examination requested," which statement must be signed by the physician sending in the specimen.

Dr. Miller: I move the adoption of this resolution.

Motion seconded and unanimously carried.

Dr. Clark: One other matter. Mr. Pres-

ident. In the report of the Secretary of the Committee on Hospitals the recommendation was made that the Committee be continued. The report was adopted with the understanding that they would continue the Committee. In order that it may be clearly understood I wish to state that since the death of Dr. McGee as Chairman Dr. Cleveland Thompson has done a great amount of work and it would be difficult for a new man to serve as well.

I move that the incoming President be requested to continue this Hospital Committee for another year with Dr. Thompson as Chairman, the vacancy caused by the death of Dr. McGee to be filled by the President.

Motion seconded and unanimously carried.

The Secretary reported the action taken by the Council in regard to the various matters referred to it, and upon motion duly seconded and carried the action of the Council was ratified.

Dr. Reavis: I wish to bring up for action the matter of establishing a branch office of the State Board of Health Laboratory in the Southern part of the State so that more use may be made of its facilities, for distributing serums, etc.

I move that the Medical Association of Georgia go on record as endorsing a branch to be established somewhere in the Southern section of the State.

Motion seconded and carried.

Dr. Reavis: I now wish to move, Mr. President, that a committee from the Medical Association of Georgia be appointed by the incoming President to investigate and report at the next meeting of the House of Delegates a plan whereby a home could be established in Georgia for the maintenance and care of physicians who are unable to take care of themselves in their old age. I am sure it would not cost each member more than \$50.00 to \$100.00 to work out such a plan.

Motion seconded.

Dr. C. Thompson: I think it would be well to consider some means of relief but I believe the establishment of a home for physicians is not wise. I believe we should consider group insurance of the Medical Association or something of that sort.

Dr. Reavis' motion was put to a vote and carried.

*Report of Auditing Committee:* Dr. C. D. Wheelchel, Chairman, presented the following report:

To the Council of the Medical Association of Georgia: We, the Committee appointed by the Chairman of the Council to audit the books of the Secretary-Treasurer of the Medical Association of Georgia make the following report: We checked all vouchers with



an adding machine, also with bank statement for past year, and find same correct.

Respectfully submitted:

CLEVELAND D. WHELCHER,  
Chairman.

M. M. HEAD,  
C. THOMPSON.

Dr. Wheelhel moved the adoption of the report.

Motion seconded and unanimously carried.

#### NOMINATION OF COUNCILLORS:

Fifth District: Dr. E. C. Thrash, Atlanta.

Sixth District: Dr. M. M. Head, Zebulon.

Seventh District: Dr. M. M. McCord, Rome.

Eighth District: Dr. S. D. Brown, Royston.

The President: Is there any further business before the House? If not, I will entertain a motion to adjourn.

On motion of Dr. Clark, seconded by Dr. Davison, the House of Delegates adjourned at 9:50 A. M. *sine die*.

#### FINANCIAL STATEMENT

Balance in Bank, May 1, 1924.....	\$ 6,609.88
Total receipts from all sources, May 1, 1924, to May 1, 1925.....	12,662.36
Total to be accounted for.....	19,272.24
Balance in Bank, May 1, 1925.....	7,182.68
Total expenditures, May 1, 1924, to May 1, 1925, as per vouchers attached.....	12,089.56
Total accounted for.....	19,272.24

#### VOUCHERS

No.	Description	Amount
375—E. K. Large, Postmaster		
Postage .....	\$ 20.00	
376—Allen H. Bunce, M.D.		
Salary for May.....	150.00	
377—Allen H. Bunce, M.D.		
Office space, steno-bookkeeper.....	75.00	
378—Dr. John W. Daniel		
President's Honorarium .....	150.00	
379—Dr. J. L. Campbell		
Cancer Commission. Multigraphing of letters, postage, stenographic service. Balance of appropriation for 1923-24.....	66.22	
380—Dr. J. O. Elrod		
Expenses incurred as Councillor, 1922- 23-24 .....	24.70	
381—The Publishers Press		
Printing April issue of Journal.....	537.68	
382—Massachusetts Bonding & Ins. Co.		
Bond for Secretary-Treasurer .....	7.50	
383—H. M. Fullilove, M.D.		
Expense incurred incidental to Coun- cil matters .....	11.55	
384—Atlanta Envelope Co.		
Voucher checks .....	27.43	
385—M. M. McCord, M. D.		
Expense incurred as Councillor.....	30.00	
386—Lester Book & Stationery Co.		
File .....	2.10	
387—Aulds, Inc.		
Gold screw back button (President's pin) .....	3.50	
388—The Lilley Co.		
Badges, postage and insurance.....	66.34	
389—Two Cent Letter Co.		
Multigraphing of letters, filling in, etc. .....	19.77	
390—V. O. Harvard, M.D.		
Expense incurred as Councillor.....	29.02	
391—Chas. Usher, M.D.		
Expense incurred as Councillor.....	12.00	

No.	Description	Amount
392—Southern Press Clipping Bureau		
Clippings for April .....	5.00	
393—Mr. Fred N. Standbridge		
For 22 memberships to the Medical Asso. of Ga. ....	22.00	
394—Allen H. Bunce, M.D.		
Salary for June .....	150.00	
395—Allen H. Bunce, M.D.		
Steno-bookkeeper, office space etc. ....	75.00	
396—The Publishers Press		
Printing the May issue of Journal.....	382.68	
397—Lester Book & Stationery Co.		
Letter folders, 2nd sheets, etc.....	8.75	
398—Southern Engraving Co.		
To invoices Nos. 2030, 2073 and 2074 (for cuts in Jrl.) .....	13.73	
399—Bryan & Middlebrooks		
In Re: Freeman vs. Dr. Check and Dr. Claxton .....	50.00	
400—E. K. Large, Postmaster		
Stamps .....	30.00	
401—Allen H. Bunce, M. D.		
Salary for July .....	150.00	
402—Allen H. Bunce, M.D.		
Steno-Bookkeeper, office space, etc.....	75.00	
403—Donaldson-Woods Co.		
25M envelopes .....	146.62	
404—J. W. Palmer, M.D.		
Delegate to A. M. A. meeting in Chicago .....	100.00	
405—Allen H. Bunce, M.D.		
Delegate to A. M. A. meeting in Chicago .....	100.00	
406—Cleveland D. Welcher		
Expenses entailed in capacity of Coun- cillor .....	102.63	
407—The Publishers Press		
June issue of Journal .....	410.68	
408—Southern Engraving Co.		
Cuts marked Young-Jones .....	16.08	
409—Southern Press Clipping Bureau		
Clippings for June .....	5.00	
410—Irene Hilton Snyder		
Stenographic services in Re: 1924 meeting .....	445.60	
411—J. P. Stevens Engraving Co.		
President's letterheads and envelopes .....	18.57	
412—Addressograph Co.		
Labor, alloy plates .....	5.62	
413—Two Cent Letter Co.		
Multigraphing letters .....	13.50	
414—C. K. Sharp, M.D.		
Expenses incurred as Councillor.....	8.25	
415—Allen H. Bunce, M.D.		
Salary for August .....	150.00	
416—Allen H. Bunce, M.D.		
Steno-bookkeeper, office space, etc.....	75.00	
417—Miss Francis Smith		
Special stenographic work during July .....	27.50	
418—Mrs. W. F. Goodroe		
Operating addressograph for March, April, May and June. Total of 91 hours .....	45.50	
419—E. K. Large, Postmaster		
Stamps .....	30.00	
420—Millers Book Store		
Files, cards, etc. ....	33.78	
421—The Publishers Press		
Printing July issue of the Journal.....	474.96	
422—Thos C. Thompson, M.D.		
Expenses incidental to Council meet- ings .....	34.00	
423—S. J. Lewis, M.D.		
Expenses incidental to Council meet- ings .....	36.38	

No.	Description	Amount	No.	Description	Amount
424—Allen H. Bunce, M.D.			455—E. K. Large, Postmaster		
Salary for August ..	150.00		Stamps for mailing 151 form letters to		
425—Martha Irwin			advertisers, sample copies of Journal,		
Salary as assistant to Secretary Treas-			notices in regard to unpaid 1924 dues	30.00	
urer ..	100.00		456—Allen H. Bunce, M.D.		
426—Underwood Typewriter Co.			Salary for December ..	150.00	
Underwood Typewriter 5-1836983 P...	102.50		457—Martha Irwin		
427—The Publishers Press			Salary as Asst. to Secretary-Treasurer		
Printing August Journal ..	383.69		(Dec.) ..	100.00	
428—Southern Press Clipping Bureau			458—Dr. Frank Bird, Secretary Lowndes Co.		
Clippings for August ..	5.00		Med. Society.		
429—Southern Engraving Co.			Refund-paid dues of Dr. P. C. Q., twice	5.00	
2 Cooper plates and photograph of			459—Mrs. F. W. Goodroe		
x-ray plates for Dr. Bazemore's ar-			Addressograph operator, 50 hours at		
ticle ..	8.50		50c per hour ..	25.00	
430—Petty Cash			460—Two Cent Letter Co.		
For office ..	10.00		Letters to each secretary and letters		
431—Martha Irwin			soliciting ads ..	19.00	
Salary as Asst. to Secretary-Treasurer	100.00		461—Bryan & Middlebrooks		
432—Allen H. Bunce, M.D.			Arnold Broyles, Clerk, costs to date		
Salary as Secretary-Treasurer ..	150.00		in case of Bryson vs. Dr. C. C. Aven	25.00	
433—Southern Engraving Co.			462—Underwood Typewriter Co.		
To invoice, September ..	8.26		Repairing typewriter ..	10.00	
434—J. P. Stevens Engraving Co.			463—Lester Book & Stationery Co.		
500 Letterheads and 500 envelopes for			200 cards, 1 envelope moistener ..	2.05	
Dr. J. O. Elrod, President ..	16.16		464—The C. A. Dahl Co., Florists		
435—Russell Electric Co.			Basket of flowers sent to President,		
To invoice—connecting telephones ..	50.34		Dr. J. O. Elrod ..	10.30	
436—Southern Press Clipping Bureau			465—Mr. J. N. Reisman		
Clippings for September ..	5.00		Office rent from Nov. 1st to Dec. 1st	21.50	
437—Massengale Bulletin System			466—Southern Press Clipping Bureau		
Lettering on door ..	2.70		Clippings for November ..	5.00	
438—The Addressograph Co.			467—Publishers Press		
Bottle of ink for addressograph ..	.84		Printing November Journal ..	396.19	
439—The Publishers Press			468—Southern Engraving Co.		
Letterheads and publishing September			Cuts to invoice No. 3594 ..	4.80	
Journal ..	456.19		469—Allen H. Bunce, M.D.		
440—Lester Book & Stationery Co.			Salary for January ..	150.00	
Paste, rubber bands, second sheets ..	7.40		470—Martha Irwin		
441—Daily Report Co.			Salary as Asst. to Secretary-Treas-		
Re: Charter for Association ..	12.00		urer (Jan.) ..	100.00	
442—Bryan & Middlebrooks			471—E. K. Large, Postmaster		
Re: Clark vs. Dr. W. R. McCall ..	112.64		Stamps for mailing Journal, member-		
443—Horne Desk & Fixture Co.			ship cards, letters, etc. ....	30.00	
Costumer, 2 chairs and waste basket	31.50		472—Southern Engraving Co.		
444—E. K. Large, Postmaster			Two cuts for Dr. Bachmann's article		
Stamps for Journal, letters ..	30.00		in Journal ..	9.00	
445—Allen H. Bunce, M.D.			473—Southern Press Clipping Bureau		
Salary for November ..	150.00		Clippings for December ..	5.00	
446—Martha Irwin			474—Lester Book & Stationery Co.		
Salary as Asst. to Secretary-Treasurer			One doz. steno note books, 600 index		
(Nov.) ..	100.00		cards ..	3.50	
447—Two Cent Letter Co.			475—Cole Book Company		
Multigraphing letter for Committee on			No. 782 Record Book ..	2.75	
Health and Public Instruction ..	8.00		476—Mr. J. N. Reisman		
448—Southern Engraving Co.			Office rent from Jan. 1st to Feb. 1st	21.50	
Cuts for November issue of Journal ..	5.80		477—The Publishers Press		
449—Southern Press Clipping Bureau			Printing December Journal and 1925		
Clippings for October ..	5.00		membership cards ..	413.69	
450—The Publishers Press			478—Bryan & Middlebrooks		
Printing October Journal and reprints			Fee for 1925—and Re: Bryson vs. C.		
"Criminal Negligence in Labeling Lye	426.19		C. Aven ..	1,066.02	
451—J. N. Reisman			479—Arnold Broyles, Clerk		
Rent for October—lumber for book			Court costs—Re: Brackett vs. Funk-		
shelves in office ..	23.50		houser ..	8.85	
452—Massengale Bulletin System			480—Allen H. Bunce, M.D.		
One name plate for directory—lettered			Salary for February ..	150.00	
in black and gold ..	6.00		481—Martha Irwin		
453—Bryan & Middlebrooks			Salary as Asst. to Secretary-Treasurer		
Reviving and renewing Charter—Costs			(Feb.) ..	100.00	
in Supreme Court of case of Bryson			482—Miller Book Store		
vs. Aven ..	75.50		Membership book ..	2.95	
454—Arnold Broyles, Clerk			483—Southern Engraving Co.		
Renewing Charter of Association to			3 cuts for Dr. L. W. Groves article ..	19.34	
June 10, 1941 ..	8.90		484—Mr. J. N. Reisman		
			Office rent from Feb. 1st to March 1st	21.50	

No.	Description	Amount	No.	Description	Amount
485	Lester Book and Stationery Co. 1/2 doz. letter box files and second sheets .....	6.50	514	E. K. Large, Postmaster Stamps .....	30.00
486	Southern Press Clipping Bureau Clippings for January .....	5.00	515	Mr. J. C. Durham Refinishing cabinet of Association .....	4.50
487	Lyon-Young Printing Co. Printing January Journal .....	395.68		Debit Ticket—Piedmont Sanatorium Ck. not Signed .....	9.00
488	Two Cent Letter Co. Letters to members not having paid 1924 dues and to each member as "booster" .....	10.15		Debit Ticket—A. P. Agee, M.D., Au- gusta, No Acct. protested. (Paid) .....	66.50
489	E. K. Large, Postmaster Stamps .....	30.00		Total Expenditures .....	\$ 12,089.56
490	Dr. N. J. Guthrie, Sec. Gwinnett County Society Refund as 50c too much was in- cluded in 1925 State dues for 7 members of Gwinnett County .....	3.50	<h2>Book Review</h2>		
491	Allen H. Bunce, M.D. Salary for March .....	150.00			
492	Martha Irwin Salary as Asst. to Secretary-Treasurer (March) .....	100.00	<h3>Methods in Surgery</h3>		
493	Howard & Timms, Binders Bounding 8 volumes of 1924 Journals .....	22.00	By Glover H. Copher, M.D., Instructor in Surgery, Washington University School of Medicine, Cloth, 232 pp., Publisher, C. V. Mosby Co., St. Louis.		
494	Southern Blue Print Co. 40 Blue Prints of exhibit space at Balt- more Hotel for 1925 State meeting .....	2.00	This book, as stated in the preface, is in- tended primarily for internes and students.		
495	Southern Press Clipping Bureau Clippings for February .....	5.00	It includes the outlines for case history tak- ing preoperative and post-operative care, operating room technic, general hospital rou- tine, etc. In addition there are outlines for taking special type histories; for example, neurologic and genitourinary. There are also presented such special procedures as blood transfusion, cholecystography, and the preoperative and postoperative care of diabetic patients.		
496	Lyon-Young Printing Co. Printing of February Journal .....	390.17	This book will hold little interest for the practitioner or surgeon. As stated above, it is intended primarily for internes, and, as such, fills a much needed place. With modifications to meet local conditions it might well serve as a "precedent book" for any hospital.		
497	Mr. J. N. Reisman Office rent from March 1st to April 1st .....	21.50	<div>DAN C. ELKIN, M.D.</div> <h3>OBITUARY</h3>		
498	Southern Engraving Co. Cuts for Dr. T. C. Davison (\$35.25) and invoice No. 4136 .....	40.15			
499	The Massachusetts Bonding & Ins. Co. Premium on \$1000.00 bond for Secre- tary-Treasurer .....	7.50	DR. FARMER HINTON LETSON, of 143 King's Highway, Decatur, died at a private sanatorium, September 2, 1925, at the age of forty-eight. Dr. Letson had been practic- ing in Decatur for the past two years, hav- ing practiced up to that time in Grantville for many years. His medical education was received at the University of Georgia, Augusta. Besides being a member of the DeKalb County Medical Society, he was a Mason and a member of the First Methodist Church. Interment was in Norcross, his native home.		
500	Two Cent Letter Co. Addressing and filling in letters .....	4.50			
501	Lester Book & Stationery Co. Red pencils, English and Medical Dic- tionary .....	13.00	DR. B. B. JAMESON died at his home in Columbus, August 25, 1925, following a long		
502	Two Cent Letter Co. One cent stamps for sending out 1650 letters for Cancer Commission .....	16.50			
503	E. K. Large, Postmaster Stamps .....	30.00			
504	Allen H. Bunce, M.D. Salary for April .....	150.00			
505	Martha Irwin Salary as Asst. to Secretary-Treasurer (April) .....	100.00			
506	Binder Picture Frame Mfg. Co. Framing colored map of Georgia .....	2.93			
507	Southern Press Clipping Bureau Clippings for March .....	5.00			
508	Lester Book & Stationery Co. 1M 3x5 plain cards, gem clips, paste and folders .....	4.95			
509	Lyon-Young Printing Co. Printing March Journal and Cancer stationery .....	425.68			
510	Two Cent Letter Co. Multigraphing letters for Cancer Com- mission (\$49.60) and letters for Associa- tion .....	57.10			
511	E. K. Large, Postmaster Stamps for mailing Journal .....	9.78			
512	Mr. J. N. Reisman Office rent from April 1st to May 1st .....	21.50			
513	Bryan & Middlebrooks Court reporter's charge in case of Umphrey vs. Wagnon .....	10.50			



illness.. Dr. Jameson was sixty-seven years of age.. He was a member of the Masonic fraternity, the Knights of Pythias and had been a prominent and beloved member of the Muscogee County Medical Society for nearly twenty years.

#### FOR SALE

I desire to sell my home, office equipment and use my influence to some good man before leaving the State. Could make him a very attractive proposition and could almost assure him a good practice to begin with. For further information address: "W. L. J.", c/o the Journal, 65 Forrest Ave., Atlanta.

#### FOR SALE AT BARGAIN!

Well established office practice in Atlanta. Completely equipped with numerous electro-therapeutic machines and other apparatus so necessary these days for the up-to-date physician. Will sell outfit for less than cost, introduce purchaser to good business and charge nothing for the practice turned over to him. I want to retire. Practiced long enough. Address reply to Dr. S., care this Journal.

## HELIOTONE



### The IMPROVED THERAPEUTIC LAMP

"HELIOTONE" is built with a new type of base requiring no counterbalances, springs or coils to help with its adjustment. It may be raised from within a few inches from the floor to a height of 7 ft. without any lifting or pulling, simply turn the levered type arm to the required angle where it locks securely in place.

#### WRITE FOR CIRCULAR OF INFORMATION—IT'S INTERESTING

FRANK S. BETZ COMPANY, Hammond, Indiana.  
6-8 West 48th Street, New York City,  
634 South Wabash Avenue, Chicago,  
3213 Swiss Avenue, Dallas.

Please send at once your circular showing details of construction and method of application of the new Betzco "HELIOTONE."

Name .....  
Address .....  
City..... State.....

## Whatever Your Question



Be it the pronunciation of **vitamin** or **marquisette** or **soviet**, the spelling of a puzzling word—the meaning of **overhead**, **novocaine**, etc., "Supreme Authority"

### Webster's New International Dictionary

contains an accurate, final answer, 407,000 words. 2700 Pages. 6000 Illustrations. Regular and India Paper Editions. Write for specimen pages, prices, etc., FREE Pocket Maps if you name this Journal.

G. & C. MERRIAM CO.,

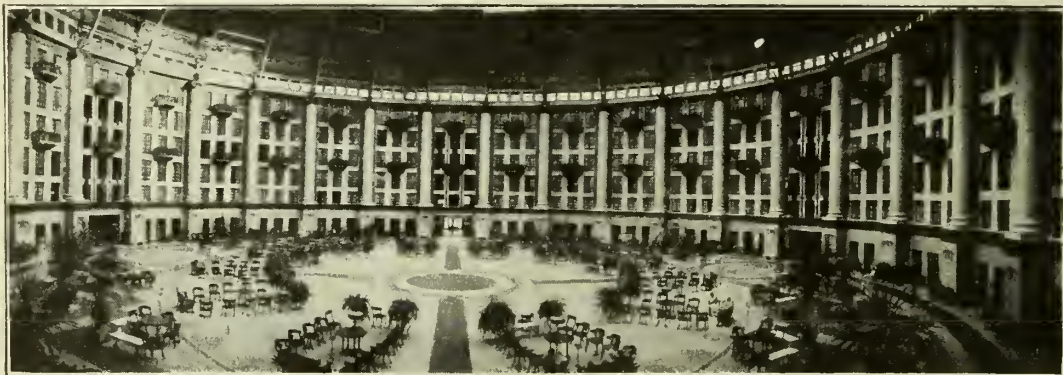
Springfield,

Mass.

# A Complete Hospital

IN A

# Famous Health Resort



*Pompeian Room of West Baden Springs Hotel—200 Ft. in Diameter*

## WEST BADEN SPRINGS, INDIANA

*The Carlsbad of America*

THIS famous spot in the foothills of the Cumberland Mountains offers the rare combination of a pleasure resort with a special department providing every modern facility for medical or surgical treatment. The physician or his patient will find at West Baden Springs Hotel whatever diversion, recreation, medical supervision or treatment may fit his needs or desires.

### *Keeping Well Is Much Easier Than Getting Well*

Periodical physical examinations—a careful checking up on the condition of the human body—is the modern and the economical method of prolonging life and enjoying good health. Health can be repaired more quickly in surroundings that are attractive and congenial like those at West Baden Springs Hotel. It com-

bines the charm of a famous resort with the most modern medical and hospital appliances where any needed physical reconstruction may be given without the severance of family ties. The equipment includes X-Ray and Physiotherapy departments and important Chemical and Bacteriological Laboratories.

### *Medical and Surgical Facilities*

The Medical and Surgical Departments occupy the top floor of the West Baden Springs Hotel; and while an integral part of the Hotel, they are a separate institution and under individual management. Physicians of recognized ability, technicians, nurses and dietitians are in atten-

dance, also graduates masseurs from Carlsbad, Austria. The Medical and Surgical Departments have been planned so as to give personal and individual attention to each patient. All baths, including the well known hot sulphur mud baths, are under the supervision of the Medical Staff.

### *West Baden Springs Hotel*

This is an ideal place for rest and recreation. It is located in the charming Lost River Valley of Southern Indiana in almost the exact center of the population of the United States. It is easily accessible from the large centers in any direction, and is a delightful place to stay under any condition. The 700 bedrooms are modern,

the cuisine excellent, the sports diversified, the atmosphere enjoyable the year round. The waters of West Baden Springs are nature's own remedy. The four springs, including the Famous No. 7, are located near the hotel. COME to West Baden Springs Hotel to ENJOY AND PROLONG LIFE.

*Write for particulars regarding rates, reservations and other information on Medical and Surgical Departments to*

C. W. DOWDEN, M. D., F.A.C.P., Med. Dir.

G. P. GRISBY, M. D., F.A.C.S., Surg. Dir.

**WEST BADEN SPRINGS HOTEL,**  
West Baden Springs, Indiana

# THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL PROFESSION OF GEORGIA  
PUBLISHED MONTHLY under direction of the Council

Volume XIV

Atlanta, Ga., November, 1925

No. 11

## Original Articles

### PEDIATRICS AND THE PUBLIC HEALTH\*

H. B. Neagle, M.D.  
Augusta, Ga.

The communicable diseases of childhood were, until a short time ago, looked upon as a necessary and unavoidable evil in every child's life. Just as every child must go thru teething, so it was supposed that he had to go thru a series of the infectious diseases.

Diphtheria, scarlet fever, whooping cough, mumps and others were always with us, and all we could do was to pray that our children not get them.

These infections, even in their mild forms, are a drain on the child's vitality and often leave him in poor health for a long time. In their more acute forms the communicable diseases are doubly dangerous. The complications that arise during an illness are often more serious than the infection itself. The impairments that some of these diseases leave, such as heart and kidney lesions, sometimes undermine the health of a lifetime.

"In the popular mind the occurrence of contagious diseases is mainly associated with the child's entrance to school and with his school life, and schools have been, and still are, looked on as being the greatest factor in the spread of these diseases. It is undoubtedly true that the close association of children in classrooms affords an ideal opportunity for transmission of any infection. The same holds true also when groups of children are gathered together anywhere else for a definite period of time. Boarding

Schools usually report epidemics of measles, chicken-pox, whooping cough or even diphtheria and scarlet fever after Christmas or Easter Holidays, whereas no difficulty is experienced in entirely eliminating these diseases from such schools if they permit no such vacations but keep their students continuously under observation."

A brief survey of the census reports for the registration area will show the fallacy of this association.

81% all deaths from contagious diseases occur in the first 4 years of life.

95% all deaths from W. C. at all ages, occur in the first 4 years of life.

80% all deaths from measles at all ages, occur in the first 4 years of life.

62% all deaths from diphtheria at all ages, occur in the first 4 years of life.

54% all deaths from scarlet fever at all ages, occur in the first 4 years of life.

Accurate morbidity reports are not easily obtained for the registration area but reports from various cities furnish abundant proof that at least 85% of all cases of contagious diseases at all ages occur during the first five years of life.

It should not be forgotten, however, that school hygiene and sanitation afford an unparalleled opportunity for the control or elimination of communicable diseases.

The experience of New York City Schools during the year 1918 when the pandemic of influenza led to the almost universal closing of schools teaches a lesson which should not be forgotten. The department of health of that city decided that the schools afforded their best opportunity for controlling the disease and concentrated its entire efforts as far as children were concerned on a pro-

\*Read before the Medical Association of Georgia, May 13, 1925.



gram of school hygiene destined to mark an epoch in the control of communicable disease.

Dr. Baker's report briefly states that "during the entire time of the influenza epidemic the rate of absence from school of either children or teachers was not greater than that reported during the same months of previous years. Moreover the age group from five to fifteen years showed the lowest incidence of occurrence of influenza or of deaths from the disease of any age group of the population. In fact it may be said that the epidemic of influenza in New York City did not affect the children of school age, and their sickness and death rates were no higher than those commonly expected at that time of year."

Another important consideration determining the value of school work in the elimination of contagious disease is the opportunity it offers for the teaching of a community of the value of control measures. Probably the wide-spread adoption of the law compelling vaccination upon admission to the public schools, intended solely as a measure to control small-pox, has done as much for health education as ever will be accomplished by any one measure. The present reaction against this law, with its accompanying disastrous results, detracts not a bit from its importance but rather enhances its educational value by demonstrating conclusively that control of small-pox still depends on vaccination. It is inconceivable that communities recently attacked by a virulent type of small-pox can be again lulled to sleep in fancied security by the arguments of fanatics or those sincerely believing in the approach of an unearned millennium while that memory persists.

No such effective campaign could be possible in any age group other than the school group both from the standpoint of economy, for every health department has most meagre provision in money and personnel, and from the standpoint of power to enforce even such a beneficial law.

The growing popularity of the Schick Test as a means of determining the immunity or susceptibility to diphtheria of school children could not progress with equal speed in the pre-school group during the present

generation because of the difficulties attached to its administration. The accompanying response of those susceptible to diphtheria as demonstrated by the Schick Test, when permanent protection is offered could hardly have been anticipated and certainly is due almost entirely to the educational features of a modern school health program.

The increase in contagion coincident with the opening of school is to be explained partially by the seasonal prevalence of certain diseases, a matter but little understood and unfortunately too little studied since the days of Hirsch. However, as Dr. Rosenau points out in his recent monograph on seasonal prevalence of disease "measles, small-pox, and influenza do not wait for winter when introduced into the South Sea Islands or into a concentration camp recruited from country districts. On the other hand scarlet fever and diphtheria do not become serious problems under a vertical sun, while colds, influenza, pneumonia, and tuberculosis play havoc in warm and tropical lands, just as they do in temperate zones."

Poorly ventilated school rooms of which too many still exist, tend to influence bodily resistance by their associated discomforts of too much heat or too much humidity. The importance of sunshine is just being recognized. The part it may play is illustrated by its therapeutic value in tuberculosis and rickets.

Epidemics are living things and are dependent upon a variety of factors of which three may be mentioned as conforming to the laws of life in general—Microbic distribution, microbial virulence and host susceptibility. To a certain extent any harvest depends primarily on the possession of seed, secondarily on the quality of the seed and thirdly on a suitable environment for growth. Other factors such as suitable temperatures, moisture, sunlight, and fertile soil influence the crop.

Communicable diseases are transmitted from one host to another and are characterized in the main by being contact diseases, or, to use the jargon of the contagious hospital, by being "arm length" diseases. Well managed contagious disease hospitals

pride themselves on their "mixed infection wards" in which are kept at the same time cases of scarlet fever, diphtheria, small-pox, chicken-pox, mumps, and even measles. All that is necessary is to separate the beds two arm lengths, see that the patients stay in bed, and allow only well trained nurses to attend the patients. Cross infections need not occur. If it were possible to correct the pernicious habit of most children and many adults of carrying the hands to the face without due regard for ordinary cleanliness the greatest problem of the control of contagion in public schools would be solved. Such a problem was solved satisfactorily in the schools of New York in 1918.

To have a second case one must have a first case of any contagious disease. Transmission, almost always by direct contact with the first case or direct contact with the secretions from the first case, to the second case of any contagious disease, depends first on the quality of the seed. In the case of typhoid fever one can build the morbidity record from the mortality record invariably. In all seasons, in all places, whether endemic or epidemic the fatality record remains very constant, but this is not true of many diseases. In general the more intimate the contact the more likelihood of catching the disease. Meader of Detroit finds the remote contacts of true diphtheria cases, even through harboring diphtheria germs in their throats, so little of a menace that he releases them from quarantine and permits their return to school. In other words where diphtheria is concerned one-fifth to one-third of all persons coming in intimate contact with cases of diphtheria will pick up and harbor the germ and approximately 50% will be of the virulent type. On the other hand these cases rarely transmit virulent bacteria to a third person but frequently transmit non-virulent strains. The direct contact case is a menace and the remote contact is not. The number of carriers is a very good index of the number of cases.

(2) The resistance or susceptibility of the host determines the success of the invading organism in its attempt to follow the first law of life which is to grow and reproduce its kind. In general, heat, moisture, dark-

ness and food are the essential needs for germ growth. Decayed teeth, diseased tonsils, or any type of unclean mouth offers better soil than a healthy clean one. A healthy body already has defenses resistant to attack to a greater or less extent, and has the power of developing other defenses at need. These defenses may be determined largely by the age of the invaded host—so strikingly shown by Parks in the case of diphtheria, and true in general of all communicable diseases—or may be developed artificially.

(3) The amount of virus invading a normal host determines largely his success in resisting attack, yet in measles and small-pox this is not apparent.

Practically all diseases of the respiratory group are cold weather diseases. Diphtheria, scarlet fever, whooping cough, mumps, measles, cerebro spinal fever, show this predilection and have been looked upon as spreading largely by the closest contacts involved in the changing customs and environment incident to the approach of winter.

Each has its own characteristics not so easily explained and deserving of brief mention. Influenza often occurs in the warmer months and sixteen great epidemics have occurred in mid summer. Infantile paralysis has a distinct summer prevalence, and in addition a marked predilection for rural distribution in contrast to the theory of crowding. It is reported that the virus is of very unstable virulence under laboratory conditions which may or may not help to explain its unusual transmission.

Cerebro spinal meningitis is usually in cold changeable weather and carriers are common in winter but rare in summer.

Scarlet fever may reach its peak any time from Fall to Spring but its peak is usually reached in January.

Diphtheria reaches its peak very regularly in cold weather but occurs in warm climates to a greater extent than scarlet fever.

Measles usually reaches its peak in May and its periodicity is very marked by cycles of two or three years.

It is very apparent that, given two factors, seed and soil, each subject to tremendous variations, great care must be exercised

in forming judgments concerning the control of contagion when almost any step taken is considered an infringement on the rights of the people.

If you grant that 85% of all contagious diseases occur before the fifth year—

If you admit that even in the respiratory group, one shows a distinct summer prevalence, one no special aversion to warm weather, and several show a decided tendency to develop toward the latter end of the school year—you must inevitably reach the conclusion that school inspection is not going to control contagion.

The tremendous advance in the control of diphtheria since the use of toxin-antitoxin in the schools is most gratifying but it should not be forgotten that certain disturbing facts have been learned.

For instance in a private school in New York containing pupils who did not live in congested districts and who spent their summers in camp only 7.5 percent gave a negative Schick while Zingher's experience in the public schools of New York showed that positive Schicks were never higher than 67% and in one school were as low as 13.6%.

This leads us to the consideration of carriers and missed cases and their importance in the scheme of control.

In a recent paper by Griswold of Iowa State he suggests a division of carriers into four groups: 1, Incubatory; 2, Convalescent; 3, Direct Contact, and 4, Remote Contact Carriers.

Under incubatory carriers he discusses the hopelessness of present methods of control in the case of measles and whooping cough. We all know definitely both by laboratory tests and by clinical experience that whooping cough is not contagious after the fourth week and certain recent experiments indicate that this length of time may be halved. Yet both measles and whooping cough are most contagious before the diagnostic symptoms appear. Scarlet fever is notorious for the number of mild, missed or abortive cases.

Dr. Griswold says "let no health officer or health organization flatter itself that it is getting at the source of the spread of infection as long as these sources are walking the streets. Mild, missed or abortive cases

will long remain more dangerous to the public at large than frank severe or typical cases.

The difficulty with convalescent carriers in the case of diphtheria is too well known to be discussed.

Direct contact carriers, by which is meant persons who have come into direct contact with an active case and become hosts of the virus constitute a menace but can be controlled as cases are controlled.

Indirect contact carriers are certainly not a menace in the case of diphtheria and very likely not in other diseases.

Coordination of office, field, and laboratory investigations to secure much useful information as regards quarantine and more expert diagnosis of incubatory carriers; will lead us as it is leading welfare workers of other types back into the pre-school field.

Let us remember that science is not fighting alone, that downward trends in tuberculosis and diphtheria are not wholly to be explained by specific measures developed in the last few years, but strong in the belief that no effort is entirely wasted direct our effort along those lines indicated by experience as most productive of results.

It may well be wise to follow in the footsteps of the laboratory worker and improve our incubators, perfect our culture media, and examine our material from the earliest possible moment with the best binoculars available if we are to produce the child most able to take advantage of the meagre knowledge we possess concerning disease and disease control.

#### **Pediatrics and Public Health No. 1.**

Percentage of deaths which occur in children under five years of age, United States Registration Area, 1920:

Cause of Death—

Cause of Death	Deaths Under 5 Years of Age
All causes .....	22%
Whooping Cough .....	95%
Diarrhea and enteritis.....	88%
Measles .....	78%
Diphtheria .....	57%
T. B. Meningitis .....	55%
Broncho pneumonia .....	53%
Scarlet fever .....	47%
Influenza .....	19%



**Pediatrics and Public Health No. 2.**

Number and percentage of deaths under five years of age, U. S. Registration Area, 1920:

Cause of Death—	Deaths Under 5 Years of Age	
	No.	P. C.
All causes	248,432	22%
Whooping cough	10,388	95%
Diarrhea and enteritis	41,634	88%
Measles	6,020	78%
Diphtheria	7,646	57%
T. B. Meningitis	2,708	55%
Broncho pneumonia	25,108	53%
Scarlet fever	1,891	47%
Influenza	12,035	19%

**Pediatrics and Public Health No. 3.**

Number and percentage of deaths under one and under five years of age, U. S. Registration Area, 1920.

Cause of Death	Total Deaths	Deaths under 1 yr.	Deaths under 5 yrs.
All causes	1,142,558	174,710 15%	248,432 22%
Whooping Cough	10,968	6,091 56%	10,388 95%
Diarrhea and Enteritis	47,605	30,944 65%	41,634 88%
Measles	7,712	1,831 24%	6,020 78%
Diphtheria	13,395	933 7%	7,646 57%
T. B. Meningitis	4,895	940 19%	2,708 55%
Broncho Pneumonia	47,746	15,941 33%	25,108 53%
Scarlet Fever	4,004	188 4%	1,891 47%
Influenza	62,097	5,633 9%	12,035 19%

**BIBLIOGRAPHY**

1. Josephine Baker, M.D.  
"Child Hygiene," Harpers, 1925.
2. U. S. Census Reports.
3. M. J. Rosenau, M.D.  
"Seasonal Prevalence,"  
"International Conference on Health Problems in Tropical America," United Fruit Company.
4. Hirsch "Handbook of Geographical and Historical Pathology," 1883.

**Discussion on Paper of Dr. H. B. Neagle**

DR. WILLIAM A. MULHERIN, Augusta, Ga.: I like the title of Dr. Neagle's paper, "Pediatrics and Public Welfare," for they are so closely allied that they are inseparable. Just in what proportion with the amount of money invested will the community get returns. I think we all realize that preventive medicine is coming strongly and that 75 per cent of preventive medicine lies with the baby and the child. That is where a great deal of our attention should be directed. I think it is a very timely paper and the Doctor presented his facts in an excellent way. We have had the impression that the infections could be controlled in the schools. His figures showed that this is not true. He showed that 75 per cent of the infection occurs before five, and we have to

attack the problem in the pre-school age. We should attack it prenatally and intra-natally, and then attack at the right point. There is no excuse for children growing up to the school age and being susceptible to these diseases. We should vaccinate the child at the age of three months against smallpox and at the age of one year he should have the toxin-antitoxin to prevent diphtheria, and typhoid vaccine a little later. He should be given the typhoid vaccine at the age of three, and we now have the Dick serum coming out, which will prevent scarlet fever. These four diseases can all be prevented. We have found as the result of Dick's work that the rash in scarlet fever is not due to the hemolytic streptococcus but to the effect of the toxins upon the skin. Therefore, the scales are not infectious and the average time to keep the scarlet fever patient in is four weeks.

I am glad Dr. Neagle called attention to the close connection between the pediatrician and general medicine. Preventive medicine, up to 75 per cent at least, lies in pediatrics and the young man just out of school will get the practice if the pediatrician does not look out.

DR. H. C. WHELCHER, Douglas, Ga.: I have been somewhat interested in public health and as we all know the longevity increase in the last few years has been due to carrying the baby through infancy and childhood. This has been due to preventive medicine in the diseases of childhood. How will we obtain the best results? It fell to my lot some two months ago to go to our Parent-Teachers Association in our small town, as we have them in practically all the small towns in Georgia. Dr. Mulherin has gone me a little better. I thought we should vaccinate the child at two years against diphtheria, but Dr. Mulherin says earlier than that and I presume that is best. However, let us all go before our home people, the mothers, and the Parent-Teachers Association, and talk about preventive medicine, and let us vaccinate the children at an early age. I believe we can do a grand work in that way, and I think we are neglecting the work in not going before the people and giving them this idea of protecting the child by these various vaccinations. I wish to stress this idea, that we should be a little bit more energetic in trying to go before our people and tell them about this work in the pre-school age. We should try to save the children by protecting them against these contagious diseases before they go to school.

DR. J. M. POER, West Point, Ga.: There are two points I wish to mention. Dr. Neagle said that at four weeks' time we

know that whooping cough is not contagious. I wish I could feel that that was absolutely true, because I am asked with every ease of whooping cough, "How long will it be before I can let my child go where other children are?" I am really afraid because we look upon whooping cough as one of the most damaging diseases of childhood. It is one of the terrible diseases of childhood, especially because of its complications, and I am afraid to let these patients go out too soon. I think they get rid of it sooner by using vaccine than otherwise, but I advise the parents with well children to keep them away from the child with whooping cough as long as he whoops and coughs.

In regard to scarlet fever, there are other things than the scales that produce the disease. The discharge from the nose or the ear of the patient with scarlet fever will bring about an epidemic if one is not careful. I have seen this happen. I sent a patient with mastoid trouble up to a doctor here that I had treated as long as I thought I could. I wrote the doctor a note, telling him to isolate the case as it was one of post-scarlet fever. This was three months after the acute stage. The nurse in the hospital promptly developed scarlet fever. Another child washed its face in the same pan that had been used by the child with a discharging ear and an epidemic was started in that way. We must be extremely careful about these conditions for epidemics will start from failure to observe very small things.

DR. THEODORE TOEPEL, Atlanta, Ga.: The child of today has a much better opportunity than the child of twenty years ago. We have given our advice but I think the improvement in conditions is due largely to the cooperation of the physicians and the educators. If we compare our present school buildings with those of twenty or thirty years ago we see a remarkable advance. The children have large glass windows on all sides of the room, where formerly there were only two or three windows and most of them sat in darkness. Formerly they sat two or three on a bench and now they have individual desks and opportunity for more movement. Likewise, the children are allowed to go out of doors more often. There was a time when the teacher insisted that they should remain in the schoolroom because she could not control them anywhere else. Now sunshine is given to the child, open air exercise is demanded, and then comes our medical supervision. We have made it necessary for children to be examined when they are admitted into the first grade of school. Here in Atlanta we are making an effort to have all the pedi-

atricians, with the assistance of some of the general practitioners, examine all the children who seek admittance to the kindergarten. We are in this way getting to the pre-school work. Of course, the defects are discovered much more readily by this annual examination and by the improved conditions the death rate will be greatly reduced.

One thing I wish to bring to your attention right here is that the Education Association of Georgia has requested us to examine the teachers annually. There are some teachers who should not be in the schools for they are coming in close contact with the children on account of the nature of the work they are doing.

The Education Association has asked us to examine the teachers gratuitously, and as soon as you go home tell your school directors that your County Society is ready to cooperate with them in examining the school teachers.

DR. H. B. NEAGLE, Augusta, Ga., (closing): In regard to whooping cough, Denmark has the highest death rate of all countries. It has been studied very thoroughly there because they have so many deaths and cultures from whooping cough have never been found positive after the fourth week. The whooping is merely a symptom and bears about the same relation to quarantine that peeling does to scarlet fever. In scarlet fever any discharging sinus presumably may be a source of infection, but here again we have laboratory methods which can tell us definitely whether a particular case of discharging ear is infectious or noninfectious. We have the laboratory methods both for the scarlet fever and whooping cough.

I wish to emphasize the fact that in one epidemic of scarlet fever where there was an average of thirty-five cases a day over a period of three or four months, wherever there were four or five children in the family and one frank case of scarlet fever, invariably we found one other patient with a slight rash, without any other symptoms, or a slight discharge without any other symptoms. It is the undiagnosed cases and the carriers, that are spreading scarlet fever. The frank cases can be quarantined.

The other point is that it is the immediate contact with scarlet fever, whooping cough or anything else which is the source of danger, and we can control known patients by quarantine, but the undiagnosed cases and the carriers exist as sources of remote contact and are sources of danger, except in the cases of diphtheria. Now we know that the remote contacts have very little relation to the spread of this disease.



**THE ATHENS CHILD HEALTH DEMONSTRATION\***

Thos. Bolling Gay, M.D.  
Athens, Ga.

Through what we call the Athens Child Health Demonstration the City of Athens and the Commonwealth Fund are cooperating in an endeavor to develop in Athens, as a city type, satisfactory and financially practical health conditions. To the pre-existing health activities all the various phases of health work are being added which seem necessary for a complete and well rounded city health program. The Commonwealth Fund furnishes the financial support for these added activities until the people of Athens are sure that they are worth while and are willing to support them themselves. Athens has already assumed responsibility for several added phases of work and expects to gradually take over others. The Commonwealth Fund will continue a certain amount of financial support over a period of five years. By the end of that time Athens should be supporting all health activities which are considered necessary and financially practical.

The staff now engaged in the work of the Demonstration consists of eighteen members divided into four divisions—Administrative, Medical, Nursing, and Health Education.

The American Child Health Association is cooperating with the Commonwealth Fund in its demonstration program and the staff of that association is available to us for consultation and suggestions.

From a medical standpoint our work is purely preventive in character and is carried on through cooperation with the local medical profession and all agencies for health whether public or private. In view of the fact that all the influence of the demonstration staff is constantly exerted toward educating the people to make use of the physician's services in order not only to get well but to keep well, our work must of necessity increase the need of the physician's service instead of decreasing it. We feel that this is true already and we hope that it will become more and more apparent as time goes on.

The Demonstration began its existence in Athens on January 1, 1924. While it is so organized and conducted that the health of the child and the mother is the chief point of attack, it has been fully realized from the beginning that no health program can be carried out successfully which does not include the whole community. Past experience has shown that to attain true success in any particular health project every phase of health work must be considered. We have gained little for instance in impressing upon the minds of children and parents the value of drinking milk if we do not at the same time take care of the milk dealer who is advertising his milk as the richest on the ground that it has the highest bacterial count. We keep before us then the fact that our program must be a generalized and inclusive one.

Another factor which seems of vital importance in such work as ours, is correlation. The thorough correlation of all agencies, public and private, interested in the health of the community is an essential feature of the demonstration program. We first try to keep the divisions of our own organization in close touch with one another. Then we attempt to keep the branches of our organization in intimate relationship with the local health department, with the members of the medical profession, and with such associations as the Anti-Tuberculosis Association, the Red Cross and the various fraternal and civic organizations of the city.

The advantage of this method of procedure is readily seen when applied for instance to the health examination of the school child. This examination is too often carried out as a routine procedure and so soon forgotten by all concerned. We have attempted to increase its value in the following manner: The child and the parent are prepared for the examination by the health educator's work in the school and in the parent-teachers' association. The parent is present at the examination in over fifty percent of the cases. The pediatricist of the demonstration assists the county health officer with the health examinations. The oral hygienist makes her oral examination at the same time. The school nurse is present and along with the parent hears the doctor's

\*Read before the Medical Association of Georgia, May 13, 1925.



advice so that her home visit may be made intelligently. The doctor's advice passes through the teacher's hands also in the form of a defect slip sent home to the parent by means of the child. The nurse of the Anti-Tuberculosis Association supplies information about home conditions if the case is one suspected of having tuberculosis. The physician consulted in regard to a defect found fills out a blank on the back of the defect slip stating that the defect has been corrected or his opinion of the condition. Indigent cases are cared for at clinics carried on by voluntary work on the part of the local physicians and dentists. To complete the rather long story the Rotary and Kiwanis Clubs offer cups as prizes to the schools showing the best health record and the correction of defects is one of the features of the health record.

In like manner we have attempted to correlate and keep interested all of our available agencies in each phase of our health work.

Briefly then our program is a generalized community one, pointing chiefly toward the health of the mother and child, especially emphasizing the correlation of all work and effort and aiming to cooperate with and supplement the preexisting health agencies.

To carry out this program our staff and their duties are as follows:

In the Administrative Division we have a director who is a physician with special experience in public health—an office manager with four stenographers and a statistician. This division is concerned chiefly with general direction, community organization, statistics, and record keeping.

In the Medical Division the pediatricist at present conducts ten health centers in Athens and Clarke County for infants and children under school age. These are well child conferences. Any child needing medical attention is referred to its family physician for treatment. As already stated the pediatricist also assists the county health officer with the health examinations in the schools.

The Nursing Division is composed of a supervising nurse and five nurses. The nursing program includes school nursing, general case work, prenatal and post-natal nurs-

ing, and work in the health centers.

In the Health Education Division we have a director of health education who supervises the teaching of health habits and stresses the features of proper diet in the schools—a supervisor of physical education in the schools and on oral hygienist.

Now at the end of the five year period what have we to look forward to?

Members of the Health Education Division have already been given official positions in the school system and a portion of their salaries is at present paid by the city. This division will probably become an integral part of the school system.

The work of the Administrative Division will probably pass into the hands of the county health officer and his staff.

All or a certain portion of the Nursing Division will probably be taken over by the city and county.

The work of the pediatricist being purely a question of teaching the people the value of periodic health examinations and of consulting their physicians instead of their neighbors, the druggists, and the chiropractors, will simply continue as an integral part of the private practice of the local physicians.

These are the things we are working for and we hope to be able to prove by our records later that they are worth while not only to Athens but to every city in the United States.

Athens is certainly doing her part. She has lived up to her promises and more in every detail. It is only fair to Athens also to have it plainly understood just why the demonstration was placed there. The health conditions of Athens were not worse than those of other cities of like population. The Athens people will never have to feel about us like the little girl who ran to her mother and said, "Mother, make Mary quit praying for me—some of the things she's telling God about me are something terrible." The health conditions in Athens compared favorably with those in other cities. We hope that they will soon be the best. Athens was chosen because she offered more in the way of cooperation and because it was thought that in Athens more could be accomplished than in any other city its size.

I have given you the best conception of our work that I could in the time allowed. We hope that each one of you will make the mental picture complete by visiting us in Athens and seeing things for yourself.

#### Discussion on Paper of Dr. Thomas Bolling Gay

DR. C. C. HARROLD, Macon, Ga.: I wish to know whether this work is being done in the negro schools as well as the white, what the percentage of negroes is in the schools, what the approximate percentage of the mill hands or population is and whether the mills have their own special schools. If so, whether the work is being done in the mill schools and how much money the Federal Government is spending. How many school children he has in Athens, and whether I understood Dr. Gay correctly in saying that the work would continue for five years. I agree that if the work is done and well done it will be of great benefit to the entire country.

Along these lines, Miss Kaufman of the Public Welfare is trying to get before some county this kind of work. If any of us have any influence in any of the communities that are trying to get the work, I think we should work for them so that we can see just where the work stands in Georgia.

DR. R. L. MILLER, Waynesboro, Ga.: It happened to be my pleasant lot to visit the Athens work as a delegate from the Georgia Pediatric Society. I think I have never seen anything to equal the work being done over there. I told Dr. Cary, in writing about it, that my supply of superlatives gave out completely. There is a correlation of the work of the city, the county and the common health fund, and the Anti-tuberculosis Society. They are doing the prenatal work with the mothers, they are doing the sick baby work, which is all referred to physicians, and they have a "Well Baby Clinic." They are doing the greatest possible work in the interest of the mother and baby, and the strength and health of the children of all ages in the city and county.

In fact, their work is an answer to the following little poem:

"We boast of our breed of cattle,

And plan for a higher strain.

We heap up the food of the pasture

And store up the measure of grain.

We draw on the wits of the nation

To better the barn and the pen,

But what are we doing, my brother,

To better the breed of men?"

Athens is doing that work and doing it well.

DR. GEORGE L. ECHOLS, Milledgeville, Ga.: I wish to express my very great appreciation for this paper, and I wish to stress one feature which I always attempt to stress when a subject of this sort is brought forward in the Medical Association. That is, to look after the mental side as well as the physical. You have been speaking of diseases from the head down, and we must not forget the disease that is likely to occur from the neck up. In the school 1 or 2 per cent of the children are found to be nervous, irritable, and somewhat abnormal. It is that group of children of today that fills our insane hospitals tomorrow. All of you who are working in the child guidance problem please keep that in mind.

Three days ago I had occasion to examine a twenty-one year old girl who had finished her high school and had done her work well. She had had an upset of about six days standing in which she had been tearing off her clothes and refusing to eat. After she came in she stopped talking altogether, but before she stopped talking I found that at about the age of twelve she had heard her dead sister's voice talking to her, as well as other voices, and along with that she had developed marked antisocial and asocial tendencies, which led to her insanity.

In closing I wish to urge that in these child guidance clinics we must not forget to be on the lookout for the early signs of mental diseases, which are frequently manifest in early childhood.

DR. THEODORE TOEPEL, Atlanta, Ga.: I am one of the fortunate ones who have been in Athens. I was present at the time we were invited over to see their work, and I was much impressed with the thoroughness of the work. It showed a beautiful cooperation of all the agencies that are interested in improving child health. There was no duplication of effort such as we see in so many cities and communities. The great trouble in many communities is that each one is working for his own glorification, each one is working for statistics in order to be allowed to take part in the "Community Chest" or something of that sort. That does not take place in Athens. There is no duplication of effort, there is no waste of time or money. The child is examined and gets the benefit of every cent that is spent. That is the outcome of the work in Athens. Furthermore, the community, by its happy coordination, is trained to take over an ideal condition. They are shown how much money they would save by taking over a situation such as they have in Athens. It is cheaper. Another point which im-



pressed me greatly was that the agencies that are conducting this work so well are referring all the discovered defects to the family physician, and therefore there is a harmonious outcome of a sometimes very complex situation, in which physicians say the doctor who examines the child has a preference for some certain doctor and refers all the patients to that doctor. This does not take place in Athens. The parents come with the child and are told, "Go to see your family physician and get further advice from him."

Our Committee can recommend the system most heartily to any community that wishes to adopt something like this. Go up there and see the work and if you have any money to spend, spend it in the way it is being done in Athens.

DR. J. P. BOWDOIN, Adairsville, Ga.: I just want to take your time for a minute in commending the work which is being done in Athens. We have been in contact with it and believe it is one of the best things that has ever come in our State, but it will be lost unless you know something about it.

I wish to emphasize what Dr. Toepel has just said: go to Athens and see for yourselves. If we ever better our health conditions in Georgia it must be done with the mother before the baby is born, and with the child before the age of six years. These children must have attention before they reach the school age if we are to better the conditions in our schools. This work is to run for a full five year period. Clark county and the City of Athens will get the benefit that will result, and the State at large in proportion to the interest shown. I wish to urge you doctors to take enough interest in the work being done in our State to carry it on after this demonstration has been completed.

Dr. Gay mentioned something about tuberculosis, and I wish to urge on every physician here the necessity of an early diagnosis in tuberculosis. You will find it if you hunt for it before the child reaches ten years of age, in most cases, for it is estimated that 80 per cent of all the tuberculosis is contracted before that age. We do not discover it. I wish to stress the importance of finding the tuberculosis in children.

DR. HENRY C. WHELCHER, Douglas, Ga.: The remarks of Dr. Bowdoin call to my mind that we want what he says, and I would like to have the essayist give us the financial side of the work in Athens. Should I go home to my town and say that we want to do so and so, and they will immediately want to know how much it will cost. I wish Dr. Gay would tell us what it cost Athens to do what is being done there.

DR. W. A. MULHERIN, Augusta, Ga.: I happened to be one of the Committee to go over and investigate the Athens demonstration, and I think Georgia is to be congratulated on getting one of these demonstrations. The American Child Health Association is the largest organization in the world that is directing its activities to the infant, the child and the mother. These demonstrations are begged for by every State in the Union. There are only four going on today. Two of them are in the South, one in Tennessee, the rural one, and the one in Athens, the urban. We begged for five years before we got one. Their policy is not destructive but constructive. They do not tell the local Board of Health that they know nothing, but they go ahead and help in every way possible. They give money to create certain positions that are necessary, and they are endeavoring to lift the standards of practice through preventive pediatrics to the point where Athens can carry on the work after the five year period is passed. They are correlated, as Dr. Gay brought out. They are cooperating and are trying to sell health to the community and are inviting you to come over and inspect their work. They are doing a magnificent piece of work and doing it splendidly. It is an excellent thing for Georgia to have one of these demonstrations in the State.

DR. THOMAS BOLLING GAY, Athens, Ga., (closing): I am glad I did not take up all the time with my paper so that this discussion could come out. The gentlemen have said much more than I did.

As to whether we are working with white and colored children, we are working with both and spending just as much time on one as on the other. As to the various percentages of the population in Athens, I am sorry I cannot give you the exact figures, but about 33 per cent of the population is colored. So far as the mill percentage goes, we are handling about 33 per cent, and it includes 33 per cent of the general population.

As to the amount spent on the work, of course, we are spending more money right now than Athens will spend after we leave. We will be there for five years and after that time we expect to just gradually go over into the City of Athens. We are spending \$37,000.00 a year so far as the demonstration is concerned, but this includes a number of highly paid people in our work which Athens will not need when we finish. It is hard to give definite information as to what Athens will need to spend, or any other place, but I should say that in addition to what they are already spending in Athens we could use about \$7,000.00 more



than they are spending now. I am not sure of that figure, it is just a rough guess. The period of our work extends over five years.

In reply to Dr. Echols in regard to the mental work, we have considered that part seriously, and it is just a question of how much money we want to spend and how much time we want to spend on it. We are at present trying to work out the best means of working in that mental side.

I hope you will come over and see us. We will be mighty glad to have you come and see what we are doing. We hope you will feel like the old rooster who went home and gathered his hens all around him and said to them, "You are doing fine, but here (scratching the straw off of a big ostrich egg) I brought this back with me just to show you what they are doing elsewhere." I thank you all very much.

### BETTER COLON LAVAGE\*

W. W. Blackman, M.D.  
Atlanta, Ga.

The apparatus here shown operates upon the flow-in and syphon-out principle, the same being conveniently repeated a great number of times at each irrigation. Six to nine gallons of normal salt solution is used at body temperature.

Features of the treatment are: ease and cleanliness of application; absence of undue stretching of the colon and of pain; objection-free irrigating fluid; gentle alternate filling and emptying of the successive haustra of the colon, often repeated; solution and ablation of mucus and of putrefying and fermenting material; stimulation and exercise of the atonic colon wall; relief of partial obstruction caused by adhesions; relief of spasticity in any part of the colon; freedom from fatigue or weakness for the patient; thorough cleansing and freshening of the colon without irritation.

The irrigation consumes 30 to 45 minutes. In preference to a colon tube a short, specially fashioned hard-rubber rectal pipe is used. By its shape and size it is self-retaining and it and all tubing is of 5/16 inch inside calibre. Anyone who has watched a



Gravity-and-syphon colon irrigator

barium enema under the fluoroscope find its way to the caecum in 4 minutes will not doubt that this 30 minute irrigation gets around the entire colon.

This method is not intended for the relief of impaction. The lower colon is previously emptied in the natural way or by the aid of the ordinary enema. Midway in the operation, also, the patient is allowed to go to stool after which the lavage is resumed.

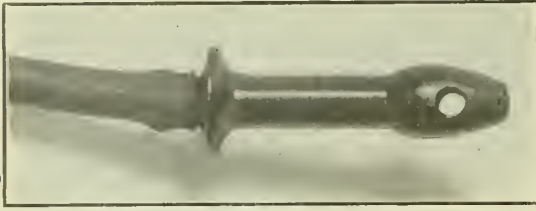
I devised this outfit to obtain the best possible two-way colon irrigation with the minimum labor for attendants in administering the treatment. It is so simple and automatic that, after one irrigation, the patient will usually take over the operation of the master valve himself so that the nurse has only to start the treatment and can thereafter be in and out of the room. A Philadelphia physician has had great success with the method. Using no valve, but only a glass Y-tube and the usual spring cut-offs, his treatments are laborious.

A largeenameled pail sets two feet higher than the patient who lies upon a table. The solution flows through the valve and into the colon. When distention begins to be uncomfortable the nurse reverses the valve and the syphon action begins. When the syphon flow ceases the valve is turned back to the first position and the inflow is repeated. This operation is done many times—

\*Apparatus exhibited before Fulton County Medical Society, April 2, 1925.

about 6 or 8 times to the gallon. The waste water from the syphon flows into a trapped drain.

Intestinal toxemia is assigned as the cause of a multitude of ailments. We usually



Large bore, self-retaining rectal pipe

mean colon toxemia. In a symposium before the Royal Society of Medicine in London upon the subject of Alimentary Toxemia, 36 toxic substances from the colon were noted, beginning with indol, skatol, and phenol and continuing through botulin, tryptophane and indolethylamine. Dr. Wm. Hunter remarked that the fact that colon stasis might exist in some individuals as an almost permanent condition without apparently causing ill-health is due solely to the power and protective action of the liver and is only evidence that some individuals possess the caecum and colon of an ox with the liver of a pig, capable of doing any amount of disin-toxication.

There exist only too many chronically engorged and infected colons which harbor clinging mucus swarming with bacteria. Prof. Kast tells his classes that such a colon presents an infective focus of the first magnitude—a thickened membrane infected from the villi and the mouths of the glands clear down to the muscularis.

There has never been found a satisfactory intestinal antiseptic that can be taken by mouth. Frederick M. Allen is emphatic in his recent statement that *Bacillus Acidophilus* and *Bacillus Bulgaricus* do not correct auto-intoxication or indican excretion.

Bacterial toxins and putrefactive compounds in excess in the colon demand that the physician "clean out, clean up and keep clean" this viscus. Infection and congestion of the colon point to mechanical drainage. These indications and others mentioned are met only by this method of thorough colon lavage.

## SPLenic ANEMIA\*

### Report of a Case

Drs. H. W. Birdsong, M. A. Hubert and  
G. O. Whelchel  
Athens, Ga.

The spleen has always more or less been an organ of mystery. Its conspicuous size, with its large blood supply has rendered its function a fertile field for speculation. While the function may not at the present time be fully understood, from the standpoint of clinical medicine, it is best considered as a filter set in the blood stream. But such a filter is not indispensable to life as has been shown by its removal without permanent ill effect, for it is believed, but not definitely proven, that in certain pathological conditions the phagocytes in the spleen have been stimulated in some way to an increased activity toward the red cells, and in removing the destructive agent it often renders the disease ineffective.

Splenic anemia, or as some say, Banti's disease (but the disease described by Banti is merely the terminal stage of the disease), is characterized by first an enlarged spleen (Idiopathic, or primitive splenomagaly), second by splenomegaly and anemia, or splenic anemia and the terminal stage by splenomegaly, anemia, cirrhosis of the liver, and ascites, or Banti's disease.

In splenic anemia you have an enlarged spleen which may extend across to the right side. It is firm, has a smooth surface, lies superficially and with the notches easily made out. There are only two other diseases, leukemia and Gaucher's disease which show regularly as large spleens. The enlarged spleen may be present for years without any other symptoms, except there may be recurrent hematemesis. With the progressive enlargement of the spleen, there develops an anemia of the cholrotic type. The anemia may last from ten to twelve years according to Osler, while others believe it to be of shorter duration. You have the pale skin, may be slightly jaundice, the feeling of ill health and the loss of appetite. There is, as a rule, no history of hereditary tendencies to this disease.

\*Read before the Eighth District Medical Society.



The blood pictures show a moderate chlorotic anemia with the average red count being about 3,425,000 per cu mm. Nucleated reds are often found. There is usually a leukopenia averaging about 4,500. The hemoglobin estimation is low and the color index less than 1. The differential picture shows nothing characteristic.

In making a diagnosis of splenic anemia, it is not at all times easy, except in the terminal stages. Some of the most important diseases to be considered and their main differential points are: the leukemias as a rule give a typical blood picture, except in the a-leukemic stage, but repeated examinations will rule out these conditions. The history of the patient with the aid of the laboratory should rule out the syphilitic and the chronic malarial spleens. In Hodgkin's disease you have the general glandular enlargements. The associated findings and clinical symptoms should make it easy to rule out tuberculosis. In pernicious anemia the blood picture gives you the diagnosis. In secondary anemia, the history of the case, with the physical examination and laboratory findings should make the diagnosis possible. Gaucher's splenomegaly is a disease of early life, history of long duration, anemia slow to develop, liver is always enlarged, and the spleen is larger than in any other disease. The patient has a feeling of well being. And when possible a splenic puncture will show you the typical cells found in Gaucher's splenomegaly.

### Report of a Case

Mrs. D., white, age 33. Occupation, nurse.

Chief complaint: Pregnancy. Anemia.

Family History: Unimportant.

Past History: Had the ordinary diseases of childhood with no complications. No history of any serious sickness until 1918. At this time she was examined for Overseas Duty as a nurse, but there was some dispute as to whether she should be allowed to go, however, after several examinations she passed, but was never told what the trouble was, or why they at first failed to pass her.

After ten months overseas she returned in May of 1919 in a pale, run-down and weak condition, but did not consult a physician at this time. After resting several months she felt better and took a position with the Veterans Bureau as a nurse.

In 1920 she began to have uterine hemorrhages. Her menstrual periods began at thirteen years of age and always were regular and normal until this time when she began suffering with menorrhagia and metarrhagia, and her anemic condition



Note pigmentation in the axilla and especially deep pigmentation around nipple

grew worse. She allowed this condition to go on until 1922 when she began to take treatments for the hemorrhages, she improved some but did not return to normal. In 1923 she was transferred to Athens, Georgia, where she consulted another physician who gave her X-ray treatments which apparently checked the excessive bleeding and her periods were regular every month, lasting about six days. She was also given treatment for her anemic condition. There is no record of any blood work at this time. Patient was married in January, 1924. Had an appendectomy in June, 1924. No history of any further trouble until present illness.

Present Illness: Patient first consulted us in Dec., 1924, at which time she was four months pregnant, and very anemic. Hemoglobin estimation at this time was 60%. Physical examination showed pigmentation of skin over abdomen and breast. Skin was of a sallow muddy appearance. B.P. 120/90. Examination otherwise negative. Patient was instructed to return later.

She was seen again in January, 1925, and was given Iron and Arsenic I.V. twice a week for two months without any noticeable improvement. She was then put on a tonic of Iron and Arsenic until time of confinement without noticeable improvement. Kidneys remained O.K. until a few days before delivery when examination showed a faint trace of albumin, which cleared up a few days after delivery. Examination on July 1st, B.P. 140/90. Hemoglobin 23%. R.B.C. 2,300,000. W.B.C. 5,000. Color index 5.



Patient delivered July 6th, 1925, male, still-born, weight 9 lbs. The head came down in occiput posterior position, was unable to deliver child in this position, so a version and extraction was done after much difficulty. Patient had a second degree laceration which was repaired. There was no excessive bleeding during or after delivery. She ran a normal post-partum course until July 10th, on which date she complained of severe headache, photophobia, dyspnoea, weakness, and felt fainty. Patient had a slight chill followed by a rise of temperature. A consultation was held and it was decided to send patient to the hospital.

Patient admitted to the hospital 10 a. m., July 10th, with temperature of 104. Pulse 130. Resp. 26, and complaint as stated above. Physical examination at this time showed patient about 33 years of age, lying in bed, very nervous, skin sallow and very anemic color. There was increased pigmentation over abdomen, breast, axillas and popliteal fossae. Eyes, conjunctiva very pale. Pupils react to light and accommodation. Abdominal examination showed on palpation a large mass in the left hypochondrium about the size of a grapefruit which was agreed upon to be the spleen. Fundus of the uterus still well above the pubis and there was slight tenderness in both lower quadrants. Lochia at this time was about normal in amount and with no offensive odor. Perineal sutures showed no evidence of infection, examination otherwise negative. Laboratory Report: Urinalysis negative. Blood Count: Hemoglobin 23%. R.B.C. 2,000,000. W.B.C. 17,500. Differential: Lymph. 15. Polys 85. Color index .5. Wassermann negative. Smear for malarial parasites negative. Stool examination negative for ova. Blood chemistry, contents per 100 cc, sugar 111 mg. N. P. N. 28 mg. Urea 15 mg. Creatinin 3 mg. Uric acid 1 mg. B.P. 90/60. At 5 p. m. Temperature was 98. Pulse 130. Resp. 20. She was given a blood transfusion of 350 cc, Lindeman method, there was no reaction except a slight rise in temperature and rash. Patient showed marked improvement, felt much stronger and dyspnoea cleared up. Blood count following day showed hemoglobin 30%. R.B.C. 2,200,000. W.B.C. 14,200. Lymph. .8. Polys 92. Color index .7. Temperature normal. On July 12th temp. rose to 102. Pulse 114. Resp. 24. On the 13th she was given another transfusion of 520 cc. by the same method with no reaction. On the next day temperature was normal and remained so until July 28th. On July 14th hemoglobin 40%. R.B.C. 2,540,000. W.B.C. 11,600. Lymph. 20. Polys. 80. Color index .8. Another blood count on July 16th showed hemoglobin 40%. R.B.C. 3,240,000. W.B.C. 8,000. Color index .6. She was given another transfusion on July 20th of 480 cc, and had no reaction. On the 21st blood count showed slight improvement, hemoglobin 50%. R.B.C. 3,200,000. W.B.C. 7,500. Lymph. 24. Polys 76. Color index .8. During this time patient had been on a nourishing diet, and on Iron and Arsenic, also had been given strychnine. Strength was improved and patient felt much better. The lochia was normal in amount and odor. Urinalysis negative. Physical examination at this time showed nothing except fundus of the uterus still above the pubis and spleen slightly enlarged.

Patient was allowed to go home where she continued to improve, was able to prop up in bed and was apparently doing nicely. On July 24th she had a moderate hemorrhage and passed a good

sized clot. Was given ergotole q 4 hrs. and the hemorrhage checked, but she has had continuous bleeding of small amount ever since. Temperature and pulse at this time was normal. On July 28th patient had a chill and temperature rose to 104.8. Pulse 126. Resp. 30. W.B.C. 6,500. Blood culture at this time was negative. Temperature continued up for 24 hours then dropped to normal. On Aug. 2nd patient began to feel chilly, weak, and had attacks of dyspnoea.

She was re-admitted to the hospital with temperature of 100. Pulse 88. Resp. 22, and was given another transfusion of 520 cc, same method as before, and had no reaction. Next day her temp. was normal, and patient passed a large blood clot. Blood count on the day following transfusion, hemoglobin 55%. R.B.C. 3,590,000. W.B.C. 2,900. Lymph 22. Polys 78. Color index .7. Consultation was held, and blood pressure at this time was 96/69. Temp. 98. Pulse 78. Resp. 16. Patient complained of being unable to sleep and was very nervous. Still had uterine bleeding. Physical examination showed slight enlargement of spleen and liver. On August the 5th another consultation was held, blood count at this time, hemoglobin 50%. R.B.C. 2,810,000. W.B.C. 6,200. Few nucleated red cells. Coagulation time 3 min. 10 sec. Color index .8. On August 6th patient was still bleeding, was carried to the operating room where without any dilatation uterus was swabbed out with iodine and silver nitrate. Uterus at this time was soft and boggy. X-ray treatments were given by Dr. Rayle on August 4th and 7th in an attempt to check the bleeding.

Patient at the present time is feeling much better and blood count shows hemoglobin 65%. R.B.C. 3,270,000. W.B.C. 7,100. Lymphocytes 35. Polys 65. Color index .9. Urinalysis negative.

## CHOLECYSTOGRAPHY

Glover H. Copher, St. Louis (Journal A. M. A., May 23, 1925), summarizes his paper as follows: Bromin and iodine are excreted in the bile after the intravenous injection of sodium tetrabromphenolphthalein or tetra-iodophenolphthalein. During a fasting period, the bromine or iodine enters the gallbladder through the cystic duct and is sufficiently concentrated there to make the gallbladder opaque to the roentgen ray for a period of from thirty to thirty-five hours. The concentration of the bromine or iodine is normally dependent on the retention of the bile in the gallbladder by the sphincter of the common duct. The maximum concentration of the bromine or iodine is reached in from sixteen to twenty-four hours after injection. The average concentration of bromine in the gallbladder, when it casts a shadow of maximum density is 0.6 per cent. The average bromine content of bile that has not entered the gallbladder is 0.2 per cent. The greater portion of the bromine in the gallbladder which produces a shadow of that organ after intravenous injection of tetrabromphenolphthalein leaves the gallbladder through the cystic duct. It is concluded that the gallbladder has a concentrating activity.

### INDIGESTION ATTACKS OFTEN WARN OF CANCER.

Every person over 40 years old who is suddenly attacked with indigestion that does not disappear after a brief period of careful diet should consider the possibility of cancer of the stomach and should seek medical advice, says Dr. Julius Friedenwald, Baltimore cancer specialist, who writes for the August Hygeia on "Simple Facts About Cancer of the Stomach."

If after a short course of medical treatment no improvement is noted, the suspicions of cancer become even greater, according to Dr. Friedenwald.

Some of the symptoms of cancer of the stomach are loss of appetite, vomiting, pain, bleeding from the stomach, passage of blood through the bowels, difficulty in swallowing food, and loss of weight.

Most of these early signs are also signs of certain other disorders, so that a thorough physical examination is necessary to determine the presence of cancer. Early diagnosis of the disease is exceedingly difficult and therein lies the danger.

Dr. William J. Mayo has demonstrated that many cures may be obtained in gastric cancer when operation is performed early. When gastric cancer is recognized sufficiently early, the person has from a radical operation at least a 90 per cent. chance of recovery, a 36 per cent. chance for a three year cure and a 25 per cent. chance for a five year cure.

The stomach more frequently than any other organ is the seat of cancer, almost half of the cases being of that nature.

### GENERALIZED EDEMA IMMEDIATELY FOLLOWING INSULIN CONTROL IN DIABETES MELLITUS

A pronounced generalized edema occurring in diabetic patients immediately following desugarization of the urine with insulin therapy was observed five times last year in the clinic, with which R. B. Gibson and R. N. Larimer, Iowa City (Journal A. M. A., Feb 14, 1925) are connected. The edema promptly disappeared after treatment with potassium bicarbonate and potassium chlorid, 0.6 gm. each, three times a day, with meals. No recurrence of the edema has been reported by the patients when the potassium therapy was discontinued on discharge. None of the patients had significant renal or cardiac disturbances. The urines of all the patients were free from acetone and diacetic acid when the edema developed. That the edema may persist for thirty days if uncontrolled was shown for one case; potassium therapy was then instituted, and the edema almost subsided in thirty-six hours.

### CENTRIC PUERPERAL PALSIES

Centric puerperal palsies are of interest to the obstetrician, the neurologist and the internist. These palsies are usually hemiplegias, though commonly the face, arm and leg are unequally involved. Infrequently monoplegias occur. A primary partial aphasia may be the forerunner. James E. Talley and Dorothy L. Ash-ton, Philadelphia (Journal A. M. A., July 4, 1925), analyze forty-two cases recorded in the literature.

### OBSTRUCTIVE ANURIA

The case reported by W. A. Myers, Kansas City, Mo. (Journal A. M. A., July 4, 1925), was one of apparently total anuria of thirty days' duration due to obstruction of both ureters by a post-operative recurrent carcinoma. There was neither motive for, nor question of, deception in this case. The patient was catheterized by two physicians, and by both nurses at various times from the fifth to the twenty-eighth day of anuria, and not a single drop of urine was found in the bladder at any time. There was no urinary odor detected on the bedcloths or gowns or in the vessel at any time. She died after at least thirty days in which no evidence of urinary excretion was noted by any one.

### MAKE "SLOW EASY" YOUR MOTTO

Make "Slow Easy" your motto, and give your brain a reasonable chance to carry on its function, that of thinking. This is the advice of Dr. James Sonnett Greene, New York physician and authority on the correction of speech defects.

Dr. Greene uses the "Slow Easy" motto in training the scores of children who come to the National Hospital for Speech Disorders to speak correctly. This hospital treats stutterers and stammerers and is the first public hospital in the country devoted wholly to the cure of the defective voice.

"The greatest boon to mankind is thought," declares Dr. Greene, who contributes an article on "Your Child's Speech" to the November Hygeia, popular health magazine published by the American Medical Association. "Anything that promotes thought is bound eventually to promote better co-ordination of all the functions of a person's mind and body; thus in its deepest meaning "Slow Easy" is a life's motto for every one.

"Parents could well make 'Slow Easy' a part of their daily routine and repeat and repeat it until it is a part of their very fiber. It is an antidote for the speech defective, for the neurotic, and for all the unnecessary hustle and rush of our American life."



# THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Profession of Georgia.

65 Forrest Ave., Atlanta, Ga.

NOVEMBER, 1925

ALLEN H. BUNCE, M. D., Editor

Publication Committee

CHAS. USHER, M. D.

S. J. LEWIS, M. D.

T. C. THOMPSON, M. D.

Articles are accepted for publication on condition that they are contributed solely to this Journal.

Manuscripts should be typewritten, double-spaced, and the original (not the carbon copy) submitted. Used manuscript is not returned unless requested.

Communications and items of general interest to the profession are invited from all parts of the State. We especially invite county society secretaries to send us information of happenings in the county that would be of interest to the members throughout the State.

Reprints should be ordered within 30 days after the appearance of an article, since all type will be destroyed at the end of that time.

## Editorial Department

### A GREATER ASSOCIATION FOR 1926

As we approach the end of the present year plans are being made to meet and solve new problems for the year 1926, through a better medical organization. Please co-operate with the secretary-treasurer of your county medical society by remitting your 1926 dues this month. Let's start the new year right!

### THE DIRECTORY ISSUE

In the December issue of our Journal will be published a directory containing the names and addresses of all our members and, also, a complete list of the officers of all constituent societies as they appear on the official roster of the Association. In order to make the directory as nearly correct as possible, a galley proof of the list of members in each county will be sent to the secretary of each county society. The secretaries will render a real service to the Association and to their individual members by making any corrections and returning the proof immediately and we wish to thank them in advance for this co-operation

It is especially gratifying to be able to announce that we now have 1,736 paid-up members for this year, whereas, at the same time last year we had only 1,572 paid-up members. This excellent showing is due to the wonderful spirit of co-operation which exists throughout the State. The secretaries of the constituent societies should receive the maximum amount of credit since we show an increase of 164 members, notwithstanding the fact that we have lost many members during the year by their removal to other states.

In order for the Association to continue all of its present activities it is necessary for us to keep our membership up to the highest point possible and we earnestly request every member of the Association to co-operate with his local and state officers to the fullest extent.

### THE AMERICAN RED CROSS

That outdoor sports are of great value to the well man is a truth easily recognized. But it remained for the American Red Cross to point the way to health, through games, for the sick man.

The great outdoors is the hope of the men at Resthaven, as U. S. Veterans Hospital No. 37 at Waukesha, Wisconsin is called.

Boxing, swimming, wrestling, tennis, golf and baseball are prescribed by the attending physicians in the treatment of warshaken nerves and administered under the direction of the Red Cross. But it is medicine that is easy to take.

Sports as a part of the hospital treatment have brought out a spirit of fun, good nature and contentment which is helping the men on the road to recovery. And while they are regaining health the Red Cross is looking out for their families.

Since the Armistice the Red Cross has spent \$53,000,000 in the services to disabled World War veterans and to the men of the Army, Navy and Marine Corps and their families.

In disaster relief work it has spent \$48,000,000 in the United States since the society was organized.

It keeps 41,000 reserve nurses ready for



great emergencies and 1,000 public health service nurses on the job.

This year it taught 138,065 children and 20,352 mothers the relation of food to health through nutrition instruction in home and school.

It gave lessons in Home Hygiene and Care of the Sick to 67,281 persons.

It taught 21,000 life-saving and 18,000 first aid.

In order that this work may go on you are asked to join the Red Cross during the Ninth Annual Roll Call, from Armistice Day to Thanksgiving, November 11 to 26.

### RESOLUTIONS OF THE WARE COUNTY MEDICAL SOCIETY

WHEREAS, the last session of the General Assembly failed to provide any increase in appropriation for health work in our state for the next two years, and,

WHEREAS, the present amount of funds now available for health work in our State is entirely inadequate to meet the demands now involved upon the State Board of Health besides not allowing anything for Health extension work and medical surveys through the State.

THEREFORE, be it resolved that the Ware County Medical Society go on record as requesting Governor Walker, in case he calls an extra session of the Legislature, to include an increased appropriation for the State Board of Health for the next two years, as the present appropriation is entirely inadequate to take care of Health situation in Georgia for two years.

BE IT FURTHER RESOLVED, that the President and Secretary of our Society be requested to dispatch this resolution to the Governor at once.

BE IT FURTHER RESOLVED, that copy of this resolution be spread on the minutes of the society and that a copy be sent the State Board of Health, and a copy to the State Medical Journal for publication.

H. J. CARSWELL, Waycross,

W. C. HAFFORD, Waycross,

J. E. PENLAND, Waycross,

Committee.

### KENTUCKY IS APPOINTING COOPERATIVE CLINICIANS

The Kentucky Board of Health is appointing cooperative clinicians throughout the State for venereal disease work. Members of the state and county medical societies who are listed by the County Health Officer as particularly interested in venereal diseases, are eligible for these appointments.

The arrangement provides for the treatment of indigent patients and for the enlightenment of the community in the venereal disease problem. The patient helps to defray the cost of drugs and of other materials by contributing according to his ability, but not to exceed two dollars. If the patient is able to pay more than two dollars, he automatically becomes a private patient. The Kentucky State Board of Health pays half of the cost of the drugs used in the treatment of indigent patients, the clinician paying the other half out of the contributions made by the patients. The State Board of Health makes available to clinicians at cost, drugs and materials to be used exclusively in the treatment of indigent patients.

Each clinician is supplied with "Venereal Disease Information" and "Social Pathology," two periodicals issued by the United States Public Health Service for use in its cooperative work with State departments of health. The Hot Springs Venereal Disease Clinic is also open to clinicians who may desire to become more fully acquainted with the various phases of venereal disease control. Strip film views of syphilis and of skin diseases simulating syphilis will also be available to the State Board of Health for use in interesting physicians and medical students in fortifying themselves in the detection and treatment of venereal diseases and in actively cooperating with the Health authorities. These films have been specially prepared by the United States Public Health Service from original photographs and negatives made available through the generosity and cooperative spirit of a number of syphilologists and dermatologists who agree with the Health Authorities that effective venereal disease control depends upon the active cooperation of the physicians and Health Departments. A representative of the United States Public Health Service is cooperating with the Kentucky State Board of Health in the furtherance of this venereal disease activity through public education regarding the nature of these diseases and the value of therapeutic and prophylactic measures.

## District and County Societies

### District Editors

- |   |   |
|---|---|
| <ol style="list-style-type: none"> <li>1. McGee, H. H., Savannah.</li> <li>2. Wood, A. W., Albany.</li> <li>3. Greer, Chas. A., Oglethorpe.</li> <li>4. Williams, C. O., West Point.</li> <li>5. Fitts, Jno. B., Atlanta.</li> <li>6. Hawkins, T. I., Griffin.</li> </ol> | <ol style="list-style-type: none"> <li>7. McCord, M. M., Rome.</li> <li>8. Carter, D. M., Madison.</li> <li>9. Bennett, J. C., Jefferson.</li> <li>10. Lee, F. Lansing, Augusta.</li> <li>11. Penland, J. E., Waycross.</li> <li>12. Cheek, O. H., Dublin.</li> </ol> |
|---|---|

### HONOR ROLL

The following is a list of 100 per cent counties for 1925. The date on which each became a 100 per cent society appears after the name of the society, together with the name of the Secretary:

1. Randolph County, Dr. G. Y. Moore, Cuthbert, December 9, 1924.
2. Dougherty County, Dr. J. A. Redfearn, Albany, December 10, 1924.
3. Pike County, Dr. M. M. Head, Zebulon, December 12, 1924.
4. Hart County, Dr. W. E. McCurry, Hartwell, January 3, 1925.
5. Warren County, Dr. A. W. Davis, Warrenton, January 14, 1925.
6. Monroe County, Dr. W. J. Smith, Juliette, January 14, 1925.
7. Lamar County, Dr. John M. Anderson, Barnesville, March 6, 1925.
8. Crisp County, Dr. Byron Daniel, Cordele, March 11, 1925.
9. Upson County, Dr. B. C. Adams, Thomaston, March 30, 1925.
10. Emanuel County, Dr. S. S. Youmans, Oak Park, May 5, 1925.
11. Stephens County, Dr. C. L. Ayers, Toccoa, May 11, 1925.
12. Turner County, Dr. J. H. Baxter, Ashburn, May 12, 1925.
13. Evans County, Dr. D. S. Clanton, Hagan, May 14, 1925.

### SEVENTH DISTRICT MEDICAL SOCIETY

The Seventh District Medical Society met in Calhoun, Georgia, Wednesday, September 30, 1925, at the First Methodist Church. The meeting was called to order at 10 A. M. by the president, Dr. Trammell Starr, of Dalton. Dr. M. M. McCord, of Rome, was in his place as Secretary. At the end of the morning session the meeting adjourned to the Woman's Club Rooms where a most en-

joyable luncheon was served by the women of Calhoun in cooperation with the physicians of Gordon County. After the luncheon the members of the society returned to the church where the program was resumed and completed. Everything possible was done to make it a gala day for the visitors.

The printed program was carried out as follows:

Invocation—Rev. E. D. Hale.

Address of Welcome—In behalf of City of Calhoun, Col. A. L. Henson; in behalf of Gordon County Medical Society, Dr. G. W. Mills.

Response to Addresses of Welcome—Dr. R. M. Harbin, Rome.

Reading and adoption of Minutes of last meeting.

Under reports of committees, Dr. J. P. Bowdoin, for the Committee on Public Health and Legislation, made a very interesting report. At the conclusion of Dr. Bowdoin's report Dr. Elmore made a motion which was carried as follows: For the President to appoint a committee to draft a resolution to send to the Governor in reference to the society's attitude toward the State Board of Health and requesting that if a special session of the legislature be called that the needs of the State Board of Health be included in the call. The committee appointed was Drs. B. V. Elmore, M. M. McCord and W. R. Richards.

The scientific programme was taken up as follows:

1. Recent Studies on the Cause and Treatment of High Blood Pressure—Dr. Allen H. Bunce, Atlanta. Discussed by Drs. M. M. McCord, R. C. Maddox, W. H. Lewis and R. M. Harbin.

2. Obstruction of the Ureters—Dr. John L. Garrard, Rome. Discussed by Dr. W. H. Lewis.

3. Abscess of Spleen: Report of a case—Dr. H. M. Hall, Cedartown. Discussed by Dr. J. T. McCall, Rome.

4. A Plea for a More Thorough Examination: Report of 100 cases—Dr. R. G. Maddox, Rome. Discussed by Drs. M. M. McCord, J. T. McCall, R. M. Harbin, A. C. Shamblin, H. J. Ault and J. P. Bowdoin.

5. "Goiter"—Dr. William Howard Lewis, Rome. Discussed by Drs. Frank K. Boland and Harrison, Atlanta.

6. The Greatest Needs of the Medical Profession of Georgia—Dr. Frank K. Boland, Atlanta. Discussed by Dr. Trammell Starr, Dalton.

7. "Case Report"—Dr. R. B. Chastain, Calhoun. Discussed by Drs. Frank K. Boland and R. C. Maddox.

8. Radium Therapy—Dr. W. E. Benson, Marietta. Discussed by Drs. J. T. McCall and R. M. Harbin.

9. Dr. R. E. Wilson, of Cartersville, made a very interesting report on the activities of the Children's Free Clinic of Bartow County, located at Cartersville.

Motion made by Dr. H. M. Hall and carried extending to Gordon County Medical Society the thanks of the Seventh District Medical Society for the generous and hospitable manner in which the guests of the day had fared at the hands of their hosts.

Invitations were extended by Whitfield and Cobb Counties for the next meeting, which will be the first Wednesday in April, 1926. Cobb County won, so the next meeting will be in Marietta.

There being no further business the meeting adjourned.

M. M. McCORD, M.D., Secretary.

#### FIFTH DISTRICT MEDICAL SOCIETY

The first meeting of the Fifth District Medical Society since its reorganization was held at Douglasville, Ga., October 7, 1925.

The officers of the society are: Dr. W. Frank Wells, Atlanta, President; Dr. D. Housworth, Douglasville, Vice President; Dr. John B. Fitts, Atlanta, Secretary; Dr. E. C. Thrash, Atlanta, Councillor.

The meeting was called to order by the President.

The following program was carried out:

Call to Order 10 a. m.

Address of Welcome—Hon. D. W. Peace, Mayor of Douglasville.

Address of Welcome from Douglas County Medical Society—Dr. P. R. Whitley.

Response—Dr. F. K. Boland, Atlanta.

1. Vincents Angina Infection in the Throat—J. Calhoun McDougall, Atlanta.

2. Surgical Corrections of Deformities of the Face.—E. D. Highsmith, Atlanta, (Lantern Slides).

3. Dermatological Therapy—Jack W. Jones, Atlanta.

4. Deficiencies as Seen in Medicine—Willis F. Westmoreland, Atlanta.

5. The Clinical Chest—C. C. Aven, Atlanta.

6. Some Practical Points in the Diagnosis and Treatment of Mental Disease—Jas. W. Brawner, Atlanta.

7. Eclampsia—Marion T. Benson, Atlanta.

8. Goiter and Diseases of the Thyroid Gland.—G. Pope Huguley, Atlanta.

9. Acute Surgical Conditions Within the Abdomen—T. C. Davison, Atlanta.

10. Typical and Atypical Facial Neuralgias—Chas. E. Dowman, Atlanta.

11. Diet for the Myocardium—W. W. Blackman, Atlanta.

12. Pyelography, an Important Factor in Urological and Differential Abdominal Diagnosis—S. J. Sinkoe, Atlanta.

13. Treatment of Pelvic Inflammation, Gonorrheal and Otherwise—B. H. Wagnon, Atlanta.

14. Surgery of the Right Colon with Lantern Slides—L. W. Grove, Atlanta.

15. The Continuous Use of Oxygen in the Treatment of Pneumonia in Children—Jos. Yampolsky, Atlanta.

16. The Treatment of General Peritonitis with Special Reference to the Appendix—C. E. Waits, Atlanta.

17. The Recurrent Nuchal Ache in Chronic Malarial Cholecystostasis—Geo. M. Murray, Atlanta.

18. The Diagnosis of Pulmonary Tuberculosis—Z. S. Cowan, Atlanta.

The Douglas County Society entertained the members with an enjoyable dinner between the afternoon and morning sessions.

Respectfully submitted,

JOHN B. FITTS, M.D., Secretary.



**THOMAS COUNTY MEDICAL SOCIETY**

The Thomas County Medical Society met in regular session at the Jno. D. Archbold Memorial Hospital at five-thirty P. M., October 15, 1925. The meeting was called to order by the President, Dr. S. L. Cheshire. Minutes of the last meeting were read and adopted.

The meeting was devoted to presentation of clinical cases and case reports. Dr. C. H. Ferguson presented a case of Mongolian idiocy in a colored boy of five. It was described in a case history by Dr. Ferguson, and the case was discussed generally by the members present. The consensus of opinion being that there was not much we could do about it.

The next case was a patient presented by Dr. C. H. Watt of Thomasville. This was a radical breast amputation with theirsch grafts covering a large defect in the skin area after operation. The grafts had held nicely and the patient after a week in hospital was about ready to go home. This was discussed at some length by the society, and Dr. Watt complimented on the result obtained.

The next item on the program was a case report by Dr. A. D. Little of a very interesting case of an acute appendicitis in connection with a right inguinal hernia and a very strong simulation to renal colic. After several admissions patient came to operation and was found to have an acute appendicitis with an inguinal hernia, both taken care of at operation. Another case reported by Dr. Little was one of an undescended testis.

Dr. C. K. Wall, Thomasville, next reported an interesting case of pyloric obstruction complete from an old gastric ulcer, relieved by gastro-enterostomy.

After the meeting a very delightful dinner was served in the hospital dining room to the members.

C. K. WALL, Sec. Treas.

**FULTON COUNTY MEDICAL SOCIETY**

A very interesting meeting of the Fulton County Medical Society was held at the Academy of Medicine, 32 Howard St., Atlanta, Sept. 3rd, 1925. Dr. Theo Toepel presided. Number present 63.

Dr. O. S. Cofer presented a specimen of "Carcinoma of the Ovary." This was discussed by Drs. J. F. Denton and Geo. F. Klugh. A case report "Marked Increase of Intracranial Pressure Five Months After Trivial Accident," was read by Dr. C. E. Dowman. Dr. M. McH. Hull reported a case of "Asthma" which was of interest. The Clinical Talk was made by Dr. W. H. Hailey on "Trichophyton Infections" and discussed by Drs. W. B. Emery, A. Avary and E. D. Shanks. The paper of the evening was read by Dr. Jno. F. Denton on "Milk Injections in Acute Pelvic Infections" and discussed by Drs. B. H. Wagnon, E. H. Greene, C. E. Rushin and G. E. Clay.

Scientific program was concluded with the discussion of the paper, and reports of committees and announcements of interest were made.

There being no further business to come before the Society, the motion was in order to adjourn.

Departing from the usual routine of scientific programs arranged for the meetings of the Fulton County Medical Society, the evening of September 17th, the regular meeting night, was given over to a discussion of the medical profession. Dr. E. C. Davis was invited to speak on "Medical Ethics." Covering this broad subject in a very masterful manner, he pictured to the membership all the necessary characteristics embodied in the ideal medical man.

In order to gain the opinion of a representative layman as to what is needed to bring the profession and the laity to a closer understanding, each of the others' point of view, the Hon. Clark Howell was invited to address the membership on the subject, "A Layman's Point of View Concerning the Medical Profession." Mr. Howell with his usual wit and ability handled his subject very creditably.

Several announcements were made and particular attention was called by Dr. W. F. Wells to the meeting of the 5th District Society to be held Oct. 7, 1925, at Douglasville, Ga.

Another interesting meeting of this Society was held Thursday evening, October first, at the Academy of Medicine, 32 Howard St., Atlanta, Ga. There were seventy-eight present.

Drs. S. Stampa and W. E. Person presented a patient with "Unusual Traumatic Rupture of the Sigmoid." Dr. T. C. Davison presented a patient with "Breast Amputation with Plastic Replacement by Fat Graft." This case was discussed by Drs. D. Y. Sage, W. S. Goldsmith and J. L. Campbell.

Dr. G. A. Williams reported a case of "Eventration of Abdominal Viscera." Dr. E. C. Thrash reported a case of "Cerebrospinal Syphilis Treated by Intravenous Injections of Tertian Malarial Parasites." This case report was discussed by Drs. N. M. Owensby and Arch Smith.

The Clinical Talk by Dr. Marion Pruitt was on "Immediate Arrest of Post Partum Hemorrhage," and discussed by Drs. F. W. Wells and E. C. Davis.

The paper of the evening was read by Dr. C. W. Strickler and the title was "Arteriosclerosis. The discussion was by Drs. J. E. Paullin, E. C. Thrash, and J. K. Fancher.

There were several announcements of importance made. Dr. Wells extended an invitation to the members to be present at the meeting of the Fifth District Society which is to be held at Douglasville, Ga., October seventh.

Dr. Theo. Toepel, President, appointed Dr. R. G. Stephens to fill the unexpired term on the Board of Censors in the absence created by the resignation and removal of Dr. A. G. Fort.

Meeting adjourned.

Respectfully submitted,

GRADY E. CLAY, Secretary.

### CORRECTION

Dr. V. O. Harvard, Councillor for the Third District, has called our attention to the fact that Crisp County has been 100 per

cent since March 11, 1925, and should have been on the "Honor Roll." We were very glad, indeed, to learn this and are happy to place them on the "Honor Roll." Dr. T. E. Bradley, Cordele, is President of this Society of 18 members; Dr. A. J. Wheelchel, Cordele, Vice-President, and Dr. Byron Daniel, Cordele, Secretary-Treasurer.

### NEWS ITEMS

The many friends of Dr. J. R. McCord will be interested to learn that he has removed his offices from 373 Courtland Street to 61 Forrest Avenue, Atlanta. Dr. McCord limits his practice to Obstetrics and Gynecology.

Dr. J. H. Nicholson is being welcomed as a new member of the medical profession in Atlanta. He has opened offices in the Candler Building. Before leaving two years ago for Pennsylvania, where he took a post-graduate course and a year's internship, Dr. Nicholson practiced in Madison and was the capable Secretary-Treasurer of the Morgan County Medical Society.

We regret that one of our best, Dr. S. A. Clark, had such a bad case of "Florida Fever" that he opened up offices at 209 E. Main Street, Lakeland, Florida. We hope that he will soon recover and return to Eatonton and his office as Secretary-Treasurer of the Putnam County Medical Society.

Drs. James N. Brawner and Albert F. Brawner announce the removal of their offices and the city office of Brawner's Sanitarium from the Grant Building to 79 Forrest Avenue, Atlanta. Their Sanitarium, an ad of which appears on page VIII, is located near Smyrna and devoted to the treatment of diseases of the nervous system.

Dr. A. G. Fort, formerly having offices at 436 Peachtree Street, Atlanta, is receiving the best wishes of his friends for continued success in his new location, 544 W. Flagler Street, Miami, Fla.

Dr. J. H. Mull, the efficient Secretary-Treasurer of the Floyd County Medical Society, has returned to Rome after taking a six weeks course at Johns Hopkins in orthopedic surgery and fractures. Dr. Mull made the trip in his car and was accompanied by his wife and little son.

Georgia was certainly the loser and Florida the gainer when Dr. George L. Cook changed his address from 54 Forrest Avenue, Atlanta, to the Citizens Bank Building, Tampa.

Dr. J. O. Elrod, of Forsyth, and 1924-1925 State President, has been appointed by Governor

Walker to fill the vacancy caused by the resignation of Dr. W. C. Williams, of Cochran, on the State Board of Medical Examiners.

Dr. James R. Bean, Bacteriologist of Savannah, was given a reception by the officials and employees of the Savannah Health Department before leaving for Jacksonville to become Director of Laboratories for the State of Florida. He was presented with a black leather motorist luncheon kit, fully equipped. This was presented by Dr. V. H. Bassett, Health Officer.

Dr. C. A. Witmer has moved his offices from the Plant Building to the Walker Building, Waycross. Dr. Witmer is a member of the Ware County Medical Society and one of its past Presidents.

Dr. J. Wade Chambliss, of Americus, and President of the Sumter County Board of Health, filled the position as Sumter County Health Officer until the installation of Dr. W. H. Houston. This vacancy was caused by the removal of Dr. J. W. Payne to Miami, Florida, where he is now doing general practice.

Dr. Charles E. Dowman, 65 Forrest Avenue, Atlanta, read a paper, "Typical and Atypical Facial Neuralgias" before the regular meeting of the Atlanta Neurological Society, which was held September 25, 1925.

A tonsil and adenoid clinic was held at Dr. C. T. Nolan's Sanitarium, Marietta, September 8, 1925, under the auspices of the Cobb County Board of Health. The charge was fifteen dollars and only those who were unable to pay the regular price were admitted.

Drs. George L. and George H. Alexander have established a hospital in Forsyth. This institution has long been needed and the people are making use of its advantages.

Dr. M. F. Carson, formerly of Griffin but now of Miami, has made himself very well known in Florida. It is alleged that Dr. Carson was offered a license to practice in Florida for \$1,000 by Dr. William J. Buck, of the State Board of Medical Examiners. Dr. Buck tendered his resignation as a member of the Board, which was accepted by the Governor. Dr. Carson has been commended by the profession and asked to make talks before the Angler's Club and the Chamber of Commerce.

Dr. Dunbar Roy has been honored by the Executive Committee of Emory University, having been elected Emeritus Professor of Oto-Rhino-

laryngology. Dr. Roy has served thirty-one years as professor in the Medical Department and has taught more than 2,000 medical students now practicing in various parts of the United States.

Dr. E. R. Harris, a prominent physician of Winder, and a member of the Barrow County Medical Society, recently left for the Canal Zone to take special post-graduate work. He will be joined later by Mrs. Harris.

We were informed by Dr. Charles Usher, Savannah, Chief of the Staff, that a complete x-ray unit has been installed in the Savannah Hospital. This is a 65 bed Hospital and is located at 116 E. Huntingdon Street.

Dr. Jacob Pope Eberhardt, of Elberton, is now at the University of Georgia Hospital, Augusta. He will be there until the first of January when he will leave for Rochester, Minnesota, to take a special course at the Mayo clinic in gynecology.

We were mighty glad to learn that Dr. W. C. Pumpelly had resumed his practice in the Grand Building, Macon. Dr. Pumpelly was suddenly stricken in front of his office the first part of the year and was later a patient in one of the hospitals in Washington, D. C.

Letters from Dr. W. P. Jordan, President, and Dr. Francis B. Blackmar, Secretary of the Muscogee County Medical Society were sent to the City (Columbus) Manager recommending Dr. J. D. Jungman, of Philadelphia, Pa., as Health Officer for Columbus to succeed Dr. J. A. Thrash, who has sent in his resignation. The city commission, at a recent meeting, appointed Dr. Jungman to this position.

Dr. John A. Pirkle is now practicing in Eaton, having removed from Monroe. He will be gladly received as a new member of the Putnam County Medical Society.

Dr. B. L. White has opened offices at 216 First National Bank Building, St. Petersburg, Florida. Dr. White was formerly a prominent physician of Round Oak, Georgia, and Jones County.

The September meeting of the Richmond County Medical Society was one of the best attended and most successful ever held. Drs. A. C. Wade and J. D. Gray, Augusta, presented interesting cases. "The Allergic Diseases" was the subject of Dr. Peter B. Wright's paper, with discussion led by Dr. J. D. Gray. Dr. W. C. Kellogg, Augusta, read an interesting paper on "Hay Fever." Dr. T. E. Oertel, Augusta, led the discussion. Dr.



V. P. Sydenstricker, Augusta, led the discussion of Dr. A. A. Walden's paper, "Therapeusis of Bronchial Asthma."

The members of the Butts County Medical Society cooperated with the State Board of Health in checking typhoid fever in their County. The doctors inoculated all persons unable to pay free of charge and all others for one dollar for the three treatments.

Scholarships on the Oliver-Rea Foundation for graduate study in Medicine are available at the New York Post Graduate Medical School and Hospital. Inquiries should be addressed to the Dean, 301 East Twentieth Street, New York City.

The ninety-seventh annual session of the Medical Department of the University of Georgia, Augusta, opened with an enrollment of 130 students, 38 being in the freshman class.

The National Conference on Civilian Vocational Rehabilitation was held in Cleveland, Ohio, September 29th to October 2, 1925.

### "BIOLOGICAL PRODUCTS"

This term, as commonly understood, means simply serums, or serums and vaccines. There are many other biological products, but these two predominate in professional estimation of the class as a whole. The manufacturers of serums and vaccines are licensed by the Federal Government after due investigation of the equipment, material and personnel of the plant. This ensures the quality of the finished product, up to a minimum standard.

But there is competition among the different manufacturers, and the best selling point is not simply that the goods are up to standard, but that they are better than the law requires, as good in fact as the latest discoveries in applied bacteriology render possible. Equipment above and beyond the minimum is a great advantage, and long experience is another. To give his patient the best possible service, the physician should, if he thinks there is any difference between one manufacturer's product and that of another, specify his preference in ordering supplies.

Our readers should not miss Parke, Davis & Company's advertisement headed "Differences in Biological Products" which appears in this issue.

### UNITED STATES CIVIL SERVICE EXAMINATION

The United States Civil Service Commission announces the following open competitive examination:

JUNIOR MEDICAL OFFICER  
ASSISTANT MEDICAL OFFICER  
ASSOCIATE MEDICAL OFFICER  
MEDICAL OFFICER  
SENIOR MEDICAL OFFICER

Applications for the positions listed above will be rated as received until December 30. The examinations are to fill vacancies in various branches of the Government Service.

For positions in the Departmental Service at Washington, D. C., the entrance salaries are: Junior medical officer, \$1,860 a year; assistant medical officer, \$2,400 a year; associate medical officer, \$3,000 a year; medical officer, \$3,800 a year; and senior medical officer, \$5,200 a year. Advancement in pay may be made without change in assignment up to \$2,400 a year for junior medical officer, \$3,000 a year for assistant medical officer, \$3,600 a year for associate medical officer, \$5,000 a year for medical officer, and \$6,000 a year for senior medical officer.

For positions in the field services appointments may be made at the salaries stated above or at higher or lower salaries, the entrance salary depending upon the qualifications of the appointee as shown in the examination and the duty to which assigned.

Competitors will not be required to report for examination at any place but will be rated on their education, training, and experience.

PHYSIOTHERAPY AIDE  
PHYSIOTHERAPY PUPIL AIDE  
PHYSIOTHERAPY ASSISTANT

Receipt of applications for these positions will close October 24 and November 28. The dates for the assembling of competitors will be stated on the admission cards sent applicants after the close of receipt of applications.

In the Public Health Service the entrance salary for physiotherapy aide is \$1,020 a year, with quarters, subsistence, and laundry; for physiotherapy pupil aide, \$720 a year, with quarters, subsistence, and laundry, or \$1,200 a year, without allowances; and for physiotherapy assistant, \$1,560 a year, without allowances.

In the Veterans' Bureau the entrance salary for physiotherapy aide is \$1,680 a year; for physiotherapy pupil aide, \$1,000 to \$1,400 a year, depending upon the training and experience of the appointee; and for physiotherapy assistant, \$1,320 to \$1,600 a year.

The duties of physiotherapy aides consist of administering physiotherapy in its several branches—massage, electrotherapy, hydrotherapy, mechanotherapy, thermotherapy; active, passive, resistive and assistive exercises and remedial gymnastics; keeping daily record of the work and

progress of each and every patient coming under direction and treatment; and making the required reports of the activities of the reconstruction work in physiotherapy.

The duties of physiotherapy pupil aides will be the same as those for physiotherapy aide, except that they are pupils under the supervision and instruction of the chief aide in all the work above mentioned.

The duties of physiotherapy assistants consist of administering to special cases the treatments of physiotherapy, as massage, electrotherapy, hydrotherapy, thermotherapy, mechanotherapy; active, passive, resistive, and assistive exercises and remedial gymnastics; keeping a daily report of the work in progress on each patient under the appointee's direction and treatment; and making the required reports of the activities of the reconstruction work in physiotherapy.

Full information and application blanks may be obtained from the United States Civil Service Commission, Washington, D. C., or the secretary of the board of U. S. civil service examiners at the post office or customhouse in any city.

## COMMUNICATIONS

To the Editor:

The legislature that adjourned last Sunday morning was so disappointing to me that I feel like I will just have to tell somebody about it, and who could I go to but you.

We were interested in getting more money to serve you and the State. Not one penny more was given us. The bill known as the "per capita" bill was House Bill No. 22. See the size of this number? It was introduced the very first opportunity afforded, just as soon as the house was organized; referred to the Committee on Sanitation and Hygiene, which Committee gave it a unanimous favorable report. It was back and ready for a vote in just a few days. It was called up Monday morning before a representative number of the members were in the hall. It was wise to ask for it to be tabled as a constitutional vote could not be had. The next day with a full attendance it was called up but objection was made. The next day the same thing happened. On being approached and asked why they objected both gentlemen said they did not understand it or they would not have done so, but on investigation we were told that it could be taken from the table if we would allow it

referred to the Appropriation Committee. We had to agree to this as one objector would keep it from coming to a vote. We consented; there it hung for days and weeks and finally a sub-committee was appointed. They had several days deliberation and finally in the last days of the jam it was reported unfavorable. The Senate amended the appropriation bill when it reached them, giving us \$130,000 for 1926, and \$160,000 for 1927. The house disagreed. The first Conference Committee cut us off to the same sum we have received for the past six years, namely, \$81,431.00; no increase to even take care of the natural increase in population—Why?

We had a bill amending the Constitution to make it lawful for counties to pay for gathering vital statistics introduced and passed in the Senate. It was put in at the beginning of the session. It was never brought to a vote of the house at all—Why? This bill only referred the matter to the people for a vote. It was not allowed to see the light.

We are building a new Tuberculosis Sanatorium, and a half million dollars will be put into it. We asked that \$90,000 be given for 1926 and \$250,000 for 1927 for maintenance. The building of the new institution means the release of the old one for negroes, or the taking care of about 300 patients in all. The General Assembly did not give a dollar increase for 1926 and only \$100,000 for 1927. The new institution will have to remain vacant for 1926 and not half full for 1927, and no negroes at all—WHY?

The Feeble-minded School at Gracewood was given \$10,000 increase, making a total for this institution of \$35,000; not enough to run even properly on the same basis it has been, as we have never been able to take care of it as it should be.

You cannot imagine how disappointed I am. I did my best to get these measures through and I did not succeed. The responsibility has been placed, and I promise you to do the very best I can with what I have. Will you ask with me—WHY?

Yours very truly,

T. F. ABERCROMBIE, M.D.,  
Commissioner of Health.

Dear Doctor:

The legislature has come and gone. The State Board of Health sincerely expected an adequate appropriation. Not a penny more was given; just the same as for the past six years. The Bill to take care of the Vital Statistics Registrars was not put on its passage. This Bill was to amend the law, making it comply with the constitution.

The Tuberculosis Sanatorium will have room for practically 300 patients in 1926; no money to take them. Possibly in 1927 we can take about one-third of that number. The Feebleminded School received only \$35,000 per year. Thousands upon thousands of dollars for some things, but prevention of disease gets none.

Since the free distribution of Arsphenamine has ceased we sometimes wonder what the poor people are doing. So many of them have syphilis. It would be a great service to humanity, to your town and county if you would help to find these cases and see that they get treatment in some way. Arrangements might be made with the county or city to aid. We know you are willing to do your part. In Georgia we have many expectant mothers who should receive treatment before their babies are born, that they might be born well and not die before birth or soon after. A few doses of some of the Arsphenamines at the right time would be worth so much to the state, the nation. So many innocent children have inherited syphilis; something ought to be done for them. To take care of these cases we made arrangements to sell the physicians their supplies at a very nominal price. This has worked well, but a number of our physicians and hospitals are not taking advantage of it. The prices of these products are as follows:

Arsphenamine, 0.3 gram, Neoarsphenamine and Sulpharsphenamine, 0.45 gram and 0.6 gram, 20c each; Neoarsphenamine, 0.75 gram, 25c per ampoule; Arsphenamine, 0.6 gram and Neoarsphenamine, 0.9 gram, 30c each; Arsphenamine, 3.0 gram and Neoarsphenamine, 4.5 gram, 75c each.

All of the arsphenamines are packed in original boxes of ten ampoules—no less sold, though we will assort the sizes if desired.

Keidel tubes are supplied in packages of 6, 8 and 12, at 75c, \$1.00 and \$1.50 respectively.

All are sent C. O. D., none on open account. In ordering be sure to address us at 131 Capitol Square, Atlanta.

Yours very truly,

JOE P. BOWDOIN, M.D.,  
A. A. Surgeon.

---

Americus, Georgia.

To the Editor:

Your letter enclosing resolutions of the Medical Association of Georgia urging certain amendments to the Revenue law was duly received in Americus but my being in Washington until a few days ago prevented an earlier acknowledgement. I will give the recommendations careful consideration and will present them to the Ways and Means Committee when it considers the new Revenue law. We will begin hearings in Washington next Monday on this subject.

Yours very truly,

C. R. CRISP, Congressman,  
Third District, House of Representatives.

---

To the Editor:

You have probably seen in the Atlanta papers, the announcement of a campaign to raise a fund of \$250,000 for advertising Atlanta, and carrying on the work of the Chamber of Commerce. About two-thirds of this amount will be used for advertising and publicity. In the expenditure of this fund, Atlanta proposes to advertise to America, the great resources of Atlanta and the entire State of Georgia.

We believe that this is an ideal time for Georgia as a whole to acquaint the world with the natural resources of this section, and we are hopeful that every community in the State that has not already done so, will soon launch some kind of a publicity movement. We believe that if this were done, the favorable effects upon our State would be almost immediate, and it would start a wave of prospective citizens this way that would redound to the permanent prosperity of our commonwealth. This concerted effort of hundreds of Georgia cities would be tremendously effective.



The eyes of the Nation are looking towards the Southeast. During the next twelve months, hundreds of thousands of people will travel through our state, to go to Florida, where community and state advertising and cooperation has been carried to its greatest effectiveness. We believe that the Florida development will prove a great asset to Georgia; that the development there is sweeping northward, and already there are many signs that it is sweeping on into Georgia. This is the time for all of us to think and act together. The opportunity that is knocking at our doors now may never come again in this generation, so let us all pull together so that Georgia will go forward with new enthusiasm to continue not only as the Empire State of the South, but one of the greatest and most prosperous states of the entire Union.

Yours very truly,  
W. R. SMITH, President.  
Wm. CANDLER, Gen. Chm'n.

## TRUTH ABOUT MEDICINES

### New and Nonofficial Remedies

**Solarson.**—A 1 per cent. solution of ammonium heptenchlorarsenate rendered isotonic by the addition of sodium chloride. Solarson contains from 0.255 to 0.275 Gm. of arsenic (As) in 100 Cc. Experimental evidence indicates that the arsenic of solarson is readily liberated in the system and is well utilized. It is claimed that solarson has an advantage over the cacodylates because its arsenic is better utilized, and over the arsenites in that subcutaneous and intramuscular injection produce less pain and are less liable to produce toxic effects. Solarson is used as a means of obtaining arsenic effects in the treatment of anemia, chlorosis, malaria, neuroses and dermatoses. Solarson is supplied in ampules containing 1.2 Cc. Winthrop Chemical Co., Inc., New York.

**Bismosol.**—A solution of potassium sodium bismuthotartrate (containing 35 per cent. bismuth), 10 Gm.; piperazine, 0.3 Gm., in an aqueous solution of glucose sufficient to make 100 Cc. Bismosol is proposed as a means of obtaining the systemic effects of bismuth in the treatment of syphilis (Bismuth Compounds, New and Nonofficial Remedies, 1925, p. 73). Bismosol is administered intramuscularly. It is supplied in ampules containing 1 Cc. Powers-Weightman-Rosengarten Co., Philadelphia.

**Caprokol** (Hexylresorcinol-S & D.) 2½ per cent. Solution in Olive Oil. A solution of caprokol 2.5 parts in olive oil to make 100 parts. For a discussion of the actions, uses and dosage of caprokol, see Jour. A. M. A., May 2, 1925, p. 1338. Sharp & Dohme, Baltimore.

**Scarlet Fever Streptococcus Antitoxin Concentrated (Globulin)**—P. D. & Co. A scarlet fever streptococcus antitoxin (Jour. A. M. A., May 2, 1925, p. 1338) prepared from the serum of horses treated with subcutaneous injection of toxic filtrates from cultures of scarlet fever streptococci themselves. Each Cc. neutralizes from 35,000 to 40,000 skin test doses of scarlet fever toxin. The product is marketed in packages of one syringe containing 2.5 Cc. and in packages of one syringe containing 10 Cc. Parke, Davis & Co., Detroit. (Jour. A. M. A., Aug. 8, 1925, p. 437).

**Diphtheria Toxin-Antitoxin Mixture 0.1 L.** A diphtheria toxin-antitoxin mixture (New and Nonofficial Remedies, 1925, p. 333), each Cc. containing \$.1 lethal dose of diphtheria toxin neutralized with the required amount of diphtheria antitoxin. Marketed in packages of three 1 Cc. vials; in packages of one 30 Cc. vial; in packages of ten vials, each containing three doses. Eli Lilly & Co., Indianapolis.

**Typhoid Mixed Vaccine, Prophylactic and Therapeutic.** (New and Nonofficial Remedies, 1925, p. 360). This is also marketed in packages of three 1 Cc. vials. Eli Lilly & Co., Indianapolis.

**Germicidal Tablets of Potassio—Mercuric Iodide**—P. D. & C. Tablets containing potassium mercuric iodide, potassium iodide and sodium bicarbonate, colored blue. (For a discussion of the actions, uses and dosage of potassium mercuric iodide, see New and Nonofficial Remedies, 1925, p. 239). This product is supplied in two forms: germicidal discs of potassio-mercuric iodide no. 2-P. D. & Co., each tablet representing mercuric iodide 3/8 grain, potassium iodide 3/8 grain and sodium bicarbonate 16 grains, and germicidal discs of potassium mercuric iodide 1½ grains, potassium iodide 1½ grains and sodium bicarbonate 45 grains. Parke, Davis & Co., Detroit, (Jour. A. M. A., Aug 15, 1925, p. 517).

**Smallpox (Variola) Vaccine (Glycerinated).** (New and Nonofficial Remedies, 1925, p. 342). This is also marketed in packages of one tube. E. R. Squibb & Sons, New York.

**Tetanus Antitoxin-Lilly** (New and Nonofficial Remedies, 1925, p. 333). This is also marketed in syringes containing 10,000 units. Eli Lilly & Co., Indianapolis.

Tetanus Antitoxin (Purified) (New and Nonofficial Remedies, 1925, p. 333). This is also marketed in packages of 20,000 units. E. R. Squibb & Sons, New York.

Pasteur Antirabic Preventive Treatment (Harris Modification)—Lilly (New and Nonofficial Remedies, 1925, p. 343. Supplied in emulsion in syringes ready for use. The package containing the first seven doses is sent from the nearest Lilly depot; the second package containing the last seven doses is sent out from the home office. Eli Lilly & Co., Indianapolis. (Jour. A. M. A., Aug. 22, 1925, p. 584)..

### Propaganda for Reform

McFerrin, The Humorous "Diet Specialist." Charles B. McFerrin describes himself as a "Food Scientist," "Diet Specialist," "Humorist", has his headquarters in Chicago, although he seems to sojourn largely in the South, giving lectures on "food science" and diet and organizing "courses" among women, each member, it is said, paying \$15.00 for the course. Knowing that physicians are opposed to the exploitation of the sick and the near-sick and possibly fearing that he may expect criticism from the medical profession, Mr. McFerrin anticipates the inevitable, and in places where he conducts his "courses," endeavors to placate by telling what wonderful fellows physicians are. He states to physicians that he always discourages the use of worthless "patent medicines" and advises medical examination by the physician at least twice a year. In addition to lectures that are free and the courses and prescriptions that are charged for, Mr. McFerrin has for sale health bulletins. These are a weird mixture of elementary dietetics, quotations from faddists and advertisements of fads and quackery. A good deal of the advertising in the bulletin is devoted to "Dr." Charles B. McFerrin himself. It contains advertisements of the Porter's Trufoods, Inc., and the Natur-Way Co., which have occupied the same room in the Chicago office building used by McFerrin as his headquarters. In addition to the sale of courses and individual prescriptions and health bulletins, McFerrin also charges \$2.00 for each letter of information that he writes, which would be cheap enough if the information were trustworthy. Then he has "A Corrective Dietary List" as a cost of \$5.00 and a "Special Diet For the Unborn" at \$10.00. "Dr. McFerrin's Kitchen and Dining Room Chart," printed in two colors comes at \$2.50. But the real big thing is the "Atonement Dietary Service, Dr. Charles B. McFerrin, Founder." An elaborate, 2 page question-

naire comes with the McFerrin Health Bulletin. This the prospective patient is asked to fill out and send with a remittance of \$5.00. (Jour. A. M. A., Aug. 1, 1925, p. 376.)

The Parathyroid Hormone. The recently reported studies make it more than likely that suitably prepared parathyroid extracts contain a substance or substances that will afford complete replacement therapy in the case of the totally parathyroidectomized dog. The methods thus far developed indicate that any extract of fresh ox gland that has been made by a process of weak acid hydrolysis and is sufficiently concentrated contains more or less of the active principle. It has been proposed to use as a provisional unit of potency one one hundredth of the amount of extract that will produce an average increase of 5 mg. in the content of calcium in the blood serum of the normal dog of approximately 20 kg. of body weight over a period of 15 hours. There should be no haste in a possible human application of the parathyroid hormone. Injection of even very small amounts frequently repeated have invariably proved fatal to animals when the injections were continued. (Jour. A. M. A., Aug. 8, 1925, p. 441).

Calcium in Tuberculosis. Calcium salts have been administered in the treatment of tuberculosis for various alleged reasons: to remedy calcium deficiency; to lessen inflammatory exudate; to favor calcification of lesions; and to lessen sweating and diarrhea. But calcium is not considered as an essential remedy by critical students of the subject. (Jour. A. M. A., Aug. 15, 1925, p. 539).

Hind's Honey and Almond Cream. According to an analysis reported in 1914, Hind's Honey and Almond Cream is essentially an emulsion containing alcohol, 7.28 per cent.; glycerin, 5.79 per cent.; partly saponified beeswax, 5.98 per cent.; crystallized borax, 1.49 per cent.; perfumed with oil of bitter almonds. (Jour. A. M. A., Aug. 15, 1925, p. 539).

Tuberculin in Tuberculous Adenitis. Tuberculin seems to be indicated when the disease is strictly localized, and especially in involvement of the cervical lymph gland. Its administration is carried on in the same way as in the tuberculin treatment for other purposes with doses that produce a slight local reaction but fall short of a general one. (Jour. A. M. A., Aug. 15, 1925, p. 539).

Supsalves and Mersalv. Supsalves are arsphenamin suppositories put out by the Anglo French Drug Co., and Mersalv is stated by the same firm to be a 10 per cent. ointment of metallic mercury. In 1920, the Council on Pharmacy and Chemistry report-



ed unfavorably on Supsalvs, because there was no acceptable evidence of the efficiency of arsphenamin administered rectally. Since then the inefficiency of the rectal administration of arsphenamin has been demonstrated by controlled clinical trials. The identity of the ingredients that form the base of Mersalv is not declared by the manufacturer. There is no good evidence to show that Mersalv—or any other proprietary mercurial preparation—is therapeutically superior to the official ointment of mercury.

Parke, Davis & Co.

Mereurosol Solution.

Neo-Silvol Ointment 5 per cent.

Neo-Silvol Vaginal Suppositories.

Scarlet Fever Streptococcus Antitoxin Concentrated (Globulin)—P. D. & Co.

\*\*Oat Protein Extract—Mulford, Onion Protein Extract—Mulford.

Sharp & Dohme, Inc.

Caprokol (Hexylresoreinol—S. & D.) 2½ per cent solution in Olive Oil.

E. R. Squibb & Sons:

Insulin-Squibb, 10 units, 10 Ce.

Insulin-Squibb, 20 units, 10 Ce.

Insulin-Squibb, 40 units, 10 Ce.

Insulin-Squibb, 80 units, 10 Ce.

Smallpox (Variola) Vaccine (Glyeerinated) 1 Tube Tetanus Antitoxin Purified, 20,000 units.

W. A. PUCKNER, Secretary.

Council on Pharmacy and Chemistry.

### BOOKS RECEIVED

A COMPEND OF DISEASES OF THE SKIN, by Jay Frank Schamberg, A.B., M.D., Professor of Dermatology and Syphilology Graduate School of Medicine, University of Pennsylvania; Fellow of the College of Physicians of Philadelphia; Ex-President of the American Dermatological Association; Director of the Research Institute of Cutaneous Medicine, Philadelphia, etc. Seventh Edition, Revised and Enlarged with 119 Illustrations. Price \$2.00 net. Publishers: P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia, Pa.

A COMPEND OF OBSTETRICS, especially adapted to the use of medical students and physicians, by Clifford B. Lull, M.D., Instructor of Obstetrics, Jefferson Medical College, Philadelphia; Assistant Obstetrician to the Maternity Department, Jefferson Medical College Hospital; Attending Physician,

Dept. of Gynecology and Obstetrics, Philadelphia General Hospital; Assistant attending Obstetrician, Philadelphia Lying-In Hospital. Revised. Tenth Edition. 84 Illustrations. Price \$2.00 net. Publishers: P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia, Pa.

SURGICAL CLINICS OF NORTH AMERICA: (Issued serially, one number every other month). June, 1925—Mayo Clinic Number. Volume V, Number III. 260 Pages with 115 Illustrations. Paper, \$12.00; Cloth, \$16.00 net. Publishers: W. B. Saunders, Philadelphia.

August, 1925—Chicago Number. 246 Pages with 54 Illustrations. Paper, \$12.00; Cloth, \$16.00 net. Publishers: W. B. Saunders, Philadelphia.

GYNECOLOGIC UROLOGY, by Lynn Lyle Fulkerson, A.B., M.D., F.A.C.S.; Assistant Professor of Gynecology, New York Post Graduate Medical School; Instructor in Obstetrics and Gynecology, Cornell University Medical School; Surgeon Cornell University Medical School Clinic; Associate Gynecologist Lutheran Hospital of Manhattan; Assistant Attending Gynecologist, New York Post Graduate Hospital; Fellow of the New York Academy of Medicine; Fellow of the American Urological Association. 166 Illustrations, including 86 original and 14 color plates. Price, \$6.00. Publishers: P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia, Pa.

FEEDING AND THE NUTRITIONAL DISORDERS IN INFANCY AND CHILDHOOD, by Pulius H. Hess, M.D., Professor and Head of the Dept. of Pediatrics, University of Illinois College of Medicine; Chief of Pediatric Staff, Cook County Hospital; Attending Pediatrician to Michael Reese and Englewood Hospitals; Consulting Pediatrician, Municipal Contagious Hospital, Chicago; Member of Advisory Board, Children's Bureau, Dept. of Labor, Washington, D. C. Illustrated with 42 Engravings in the Text and one full page Colored Plate. Fourth Revised and Enlarged Edition. Publishers: F. A. Davis Co., Philadelphia.

A MANUAL OF GYNECOLOGY, by John C. Hirst, M.D., Associate in Obstetrics, University of Pennsylvania. Second Edition. Revised. 508 Pages with 195 illustrations.



Price \$3.50 net. Publishers: W. B. Saunders Co., Philadelphia.

**PHYSICAL CHEMISTRY IN BIOLOGY AND MEDICINE**, by J. F. McLendon, Ph.D., Professor of Physiologic Chemistry, University of Minnesota Medical School, and Grace Medes, Ph.D., Assistant Professor of Physiologic Chemistry, University of Minnesota Medical School. 425 Pages. Illustrated. Price, cloth, \$4.50 net. Publishers: W. B. Saunders Co., Philadelphia, Pa.

**A TEXT-BOOK OF GENERAL BACTERIOLOGY**, by Edwin O. Jordan, Ph.D., Professor of Bacteriology in the University of Chicago and in Rush Medical College. Eighth Edition, thoroughly revised. 752 Pages, fully illustrated. Price, cloth, \$5.00 net. Publishers: W. B. Saunders Co., Philadelphia, Pa.

**PREVENTIVE MEDICINE**, by Mark F. Boyd, M.D., C.P.H., Member of Regular Field Staff, International Health Board of Rockefeller Foundation; Formerly Professor of Bacteriology and Preventive Medicine in the Medical Department of the University of Texas. Second Edition. Revised. 429 Pages with 135 Illustrations. Price, \$4.00 net. Publishers: W. B. Saunders Co., Philadelphia, Pa.

**AMERICAN ILLUSTRATED MEDICAL DICTIONARY** (Dorland). A new and complete Dictionary of terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Veterinary Science, Nursing, Biology and kindred branches; with the Pronunciation, Derivation and Definition. Thirteenth Edition. Revised and Enlarged. Edited by W. A. Newman Dorland, M.D. 1344 pages with 338 illustrations, 141 colors. Contains over 2500 new words. Flexible Binding, \$7.00 net; thumb index, \$7.50 net. Publishers: W. B. Saunders Co., Philadelphia, Pa.

**EMPYEMA THORACIS**, by Evarts A. Graham, A.B., M.D., Member of Empyema Commission, U. S. Army; Professor of Surgery, Washington University School of Medicine; Surgeon-in-Chief, Barnes Hospital and Saint Louis Children's Hospital. This essay was awarded the Samuel D. Groos Prize of the Philadelphia Academy of Surgery in 1920. Illustrated. Price \$2.50. Publishers: C. V. Mosby Co., 508 North Grand Boule-

vard, St. Louis. A review appears in this issue.

**METHODS IN SURGERY**, by Glover H. Copher, M.D., Instructor in Surgery, Washington University School of Medicine; Clinical Assistant to Barnes Hospital; Surgeon to out-patients, Washington University Dispensary; Visiting Surgeon, St. Louis City Hospital. Includes outlines for case history-taking, preoperative and postoperative care of patients, routines, diets, etc. Price \$3.00. Publishers: C. V. Mosby Co., 508 N. Grand Boulevard, St. Louis. A review appears in this issue.

**THE FAITH, THE FALSITY, THE FAILURE OF CHRISTIAN SCIENCE**, by Woodbridge Riley, Ph.D., Member of the American Psychological Association, Author of "American Thought from Puritanism to Pragmatism"; Frederick W. Peabody, LL.B., Member of the Massachusetts Bar and one of the lawyers from Mrs. Eddy's sons in their equity suit in which their mother's sanity was questioned, and Chas. E. Humiston, M.D., Sc.D., Professor of Surgery, College of Medicine, University of Illinois. A searching expose of the pretensions of Christian Science constituting a complete religious, moral and medical indictment of Eddyism and its claims. Price \$3.50. Publishers: Fleming H. Revell Co., 158 Fifth Ave., New York.

**THE ART OF MEDICAL TREATMENT**, by Francis W. Palfrey, M.D., Visiting Physician, Boston City Hospital; Instructor in Medicine, Harvard University. Octavo of 463 pages. Philadelphia and London: W. B. Saunders Company, 1925. Cloth, \$4.50 net.

**OBJECTIVE PSYCHOPATHOLOGY**, by G. V. Hamilton, M.D., Director of Psychobiological Research, Bureau of Social Hygiene, Inc., New York City. Price, \$5.00. Publishers: The C. V. Mosby Company, St. Louis.

**ELECTRO-THERAPY AND IONIC MEDICATION**, a Technical and Clinical Compendium, by Harold H. U. Cross, Ph.D. (Med.), Formerly Research Worker at the Stanford University, California. 155 Illustrations and 253 pages. Price \$4.50. Publishers: J. B. Lippincott Company, Philadelphia, London, Montreal.

## Book Reviews

**"Empyema Thoracts,"** by **Evarts A. Graham, A.B., M.D.; Publisher, C. V. Mosby, St. Louis**

In this monograph, Graham makes no attempt to cover the whole subject of empyema, but merely considers the fundamental principles of treatment. The essay is based on the author's own clinical experience and extensive animal experimentation. This ideal method of laboratory proof, plus clinical proof, makes his conclusions doubly valuable.

The epidemic of streptococcic empyema in the war camps in 1918 taught many valuable lessons, but the learning thereof cost many lives. The early mortality of 30% dropped to 4% when the Empyema Commission changed the method of open rib resection to that of closed drainage, and thus prevented an open pneumothorax in the early stages.

Graham has shown by experiment on human bodies and on dogs that the mediastinum offers only slight resistance in preventing collapse of the lung on the sound side. In other words, both lungs are partially collapsed with a resulting embarrassment to respiration. He likewise shows that the maximum opening in the pleural cavity compatible with life depends upon a definite relationship between the amount of air entering the lungs and the amount entering the pleural opening. Likewise whenever the vital capacity of the lungs is reduced, (that is, by pneumonia, empyema, etc), the pleural opening compatible with life becomes smaller.

The essay is a plea for three cardinal principles in the treatment of empyema.

1. Careful avoidance of open pneumothorax in the acute pneumonic stage and drainage at this time by repeated aspirations or by the insertion of drainage tube between the ribs by the trocar and canular method.

2. Prevention of chronic empyema by sterilization with Dakin's solution and obliteration of the cavity by adequate drainage in the subacute stage and inflation of

the lung by forced expiration as with blow bottles.

3. Careful attention to the nutrition of the patient.

The volume was well written; the type, printing and makup good. It should be read by every surgeon who operates in the thorax and every physician interested in the physiology of respiration.

DAN C. ELKIN, M.D.

### HUMAN CONSTITUTION

**A Consideration of Its Relationship to Disease; by George Draper, M.D., Associate in Medicine at Columbia University, New York. Publishers: Philadelphia and London—W. B. Saunders Company**

This book of 345 pages gives a full report of an enormous amount of painstaking, careful work, in which the author shows the relationship of the human constitution to disease potentiality. He has studied 298 cases comprising six disease groups and has indicated a basic constitutional difference between these groups. The author writes that this is only a beginning and that a much larger mass of observations are necessary to obtain even a foundation for conclusions. The chief value of the book lies in its standardization of methods and description of instruments. It shows the inadequacy of existing methods of observation and descriptive procedure and substitutes a uniform, accurate, scientific method of mensuration for studying the morphology of the human body. All results are fully and accurately shown in graphic charts and in tables. This admirable work is of interest to all and will be indispensable to anyone engaged in such study.

HAL M. DAVISON, M.D.

**Mother's Manual, the Coming and Care of the Baby; by Dorothy Bocker, A.M., M.D.**

"Mother's Manual" is designed to be used as a reference book answering clearly and concisely all questions that arise before the baby comes and after it arrives. The whole trend of the book is to emphasize the prevention of disease and unnecessary discomforts by proper hygiene. The book is liberally illustrated which helps to stress the



clarity of text. Weight, charts, layette patterns, and baby biography are included in this most informative book.

Doctor Bocker, the author of this work, which combines the utmost simplicity and clarity with the most authoritative medical knowledge, is a Bachelor of Science, New York University; Master of Arts, Columbia University; Doctor of Medicine, Long Island Medical College. Doctor Bocker is the author of several books and many articles on nutrition and the general hygiene of maternity and infancy. Publishers: Brentano's, New York. Price, \$2.00.

## MARRIAGES

Dr. George Foster Eubanks, Jr., and Miss Eloise Lewis were married at the North Avenue Presbyterian Church, Atlanta, November 4, 1925. Mrs. Eubanks is the only daughter of Mr. and Mrs. William Marion Lewis, of Atlanta, and Dr. Eubanks is the only son of Mr. and Mrs. George F. Eubanks, Sr., also of Atlanta. Dr. Eubanks is a recent graduate of the Emory University School of Medicine and now associated with the Wesley Memorial Hospital, Emory University, Ga. He is a member of the Sigma Nu Fraternity and Phi Chi Medical Fraternity.

## Medical Progress

### Department Editors

Anderson, W. W., Pediatrics  
Ballenger, E. G., Urology  
Bartholomew, R. A., Obstetrics  
Block, E. B., Neurology and Psychiatry  
Clay, Grady E., Ophthalmology  
Downman, C. E., Neuro-Surgery  
Eguen, M. S., Otology, Laryngology and Rhinology  
Flitts, Jno. B., Internal Medicine  
Greene, E. H., Surgery

Hodgson, F. G., Orthopedics  
Holmes, Walter R., Gynecology and Female Urology  
Jones, Jack W., Dermatology  
Klugh, Geo. F., Clinical Pathology  
Landham, J. W., X-Ray and Radium  
Pruitt, M. C., Proctology  
Thrash, E. C., Internal Medicine  
Waits, C. E., Surgery

### INTRACRANIAL TUMORS

Charles Edward Dowman, M.D.  
Atlanta, Ga.

(Continued from October issue)

Thus far intracranial tumors have been discussed in a general way, and only slight reference has been made to those symptoms and findings which point to the particular regions of the intracranial structures which may be involved. It is, of course, of paramount importance to be able to diagnose a case as one of intracranial tumor. Before treatment is attempted, every effort should be made to accurately locate the tumor. There are certain neurological manifestations which may put us right in this matter, and one should be acquainted in a general way with the typical clinical picture caused by lesions occurring in different portions of the brain. Is the tumor above or below the tentorium? If above, is it on the right side or on the left side? Is it in the frontal, temporal, parietal or occipital lobe? Is it between the hemispheres, or under the cerebrum in the pituitary region, etc? If below the tentorium is it within the cerebellum, extra-cerebellar, or within the pons? If within the cerebellum, is it on the right or left side, or in the mid-cerebellar region? If extra-cerebellar, is it in the cerebellopontile angle and if so, which side? If within the pons which side is involved, etc. All of these questions should be kept in mind and every effort made to

answer them correctly. Even in spite of most thorough investigation there will occasionally occur a case where the exact location is still a matter of uncertainty. All data should be collected and analyzed; under such circumstances it is surprising how often the exact location can be accurately predicted.

One of the points of practical interest in differentiating supra from infratentorial tumors is the early and rapid appearance of the signs of increased intracranial pressure in the latter condition. As a matter of fact these symptoms not infrequently occur before other symptoms and findings indicating cerebellar involvement present themselves. This is due to the fact that the normal flow of cerebrospinal fluid becomes obstructed very early, with the resulting distention of the lateral ventricles. There results the early development of papilledema, headaches, vomiting, etc.

**TUMORS OF THE FRONTAL LOBE:** The frontal lobe is a not infrequent site for the occurrence of tumors. These are not always easy to diagnose as the function of the frontal lobe is not entirely understood. In a general way it is thought that certain intellectual functions are located in the frontal lobe, and this is very valuable in the study of some cases. On the other hand tumors sometimes occur in which enormous damage has been done to the frontal lobe



without any noticeable disturbance of the intellect. For clinical study we divide the frontal lobe into : (1) The pre-frontal area, which does not contain motor centers and which can be electrically stimulated without the production of convulsions. This area is supposed, however, to have something to do with the intellect; (2) the post-frontal area, which contains the cortical centers for the conjugate movements of the head and eyes to the opposite side, and the motor speech centers on the left side. The posterior part of this area is the precentral convolution (pre-Rolandic area) which contains the various other cortical motor centers. The localizing symptoms which one would expect in a tumor of the pre-frontal region would be (a) disturbance of memory, (b) disorientation in regard to time, places and people, (c) deficiency of attention, (d) a tendency to childishness with display of emotion in the form of jocularity, crying spells, etc., and (e) an indifference to the usual sphincter control. Such mental symptoms may occur when either the right or left frontal lobe is involved.

When the tumor is located in the so-called post-frontal region, there may occur in addition to the symptoms enumerated above, localized epileptiform seizures involving the face, arm and leg (at times involving the whole side) on the side opposite the lesion. This depends on the degree of involvement of the pre-central convolution. Such fits may consist entirely of a deviation of the head and eyes to the side opposite the lesion, due to involvement of the centers for these movements. Generalized epileptiform convulsions may also occur, as in tumors located in other parts of the brain. Should the tumor be on the left side there may likewise be attacks of motor aphasia due to disturbance of Broca's area. Should the tumor be deep-seated or extending to the under surface of the lobe there may result a loss of smell on the same side as the lesion, due to direct pressure on the underlying olfactory bulb. When the tumor is subcortical in location there may result a difficulty or absence of movements of the head and eyes toward the opposite side. Should the growth through backward pressure cause involvement of the fibres from the precentral convolution, there may result a paralysis of the face, arm or leg on the opposite side, according to the extent of the pressure. Associated with such paralysis will be an exaggeration of the deep reflexes and a Babinski reflex, and usually an absence of the superficial reflexes on the side opposite to the tumor (i.e. on the same side as the paralysis.)

There are several other findings which not infrequently occur in frontal lobe tumors. One of the most interesting of these is a fine vibrating tremor of the outstretched fingers of the ipso-lateral side. Another symptom which may occur is a reeling ataxic gait which may simulate cerebellar disease. There are certain paths of fibres which connect the frontal lobes with the cerebellum, and it is quite possible that the ataxia which sometimes occurs in frontal lobe tumors may be thus accounted for. There is a most interesting finding which may occur in frontal lobe tumor which is of great diagnostic worth. This is a primary optic atrophy with a central scotoma on the side of the tumor and a choked disc in the opposite eye. The ipso-lateral retrobulbar neuritis can be explained by the tumor causing direct pressure on the underlying optic nerve. The fibres originating in the macular region of the retina lie in a wedge-shaped bundle toward the outer side of the nerve. The macular bundle subserves central vision, and is, from a physiological standpoint, more delicate than those bundles of fibres from other portions of the retina. If direct pressure is exerted by the tumor on the optic nerve, the fibres which suffer first are those originating in the macula. This will cause a central scotoma very early in the disease. The direct pressure probably prevents for a while the escape of the cerebrospinal fluid down the vaginal sheath into the optic nerve head on the side of the lesion, a condition which does not obtain in the nerve on the opposite side. And so, as the general intracranial pressure increases, the fluid is forced down the vaginal sheath of the opposite optic nerve causing a choked disc on this side, and a primary optic atrophy with central scotoma on the side of the lesion. When the tumor is located within the body of the frontal lobe the choking of the discs is usually first noted in the eye on the same side as the lesion. Although in cerebral tumors the greater degree of choking is sometimes present on the side of the lesion, too much importance should not be placed on this occasional finding. In subtentorial tumors the choking may begin on either side without any relation to the side of the tumor.

#### TUMORS OF THE TEMPORAL LOBE:

There are only a few centers known to exist in the temporal lobes, a fact which makes it difficult to diagnose a temporal lobe tumor in its early stages. Not infrequently such tumors are not diagnosed until they begin to press upon neighboring structures of known function.

Although the cortical centers for hearing are located in the temporal lobes, the representation is bilateral for each ear, so that a lesion of one temporal lobe will not materially affect the hearing on the opposite side. There are, however, two centers in the temporal lobes which, when involved, give rise to symptoms of great localizing value. These are the uncinate gyrus in which are located the centers of smell and taste, and Heschl's convolution, situated on the Sylvian surface of the lobe in which is stored the memory of spoken language and sounds. This latter center is present in the left temporal lobe in right-handed individuals and in the right temporal lobe in left-handed individuals. When a tumor involves the tip of the temporal lobe in the region of the uncinate gyrus, there may occur attacks characterized by hallucinations of smell. Such phenomena may initiate a generalized or localized convulsion, or may be noted after a convulsive seizure. At times they may occur independent of epileptiform attacks, and the patient may even ask others if they do not smell such or such an odor. Such hallucinations of smell may occur when either the right or left temporal lobes are affected. The attacks may be accompanied by a smacking of the lips, and are not infrequently followed by a peculiar dreamy state during which the patient may have a feeling of unreality and strangeness. This symptom of unreality is very characteristic of temporal lobe involvement and may sometimes occur independent of the hallucinations of smell and taste.

When the tumor involves the transverse gyri of Heschl in the left temporal lobe in right-handed individuals (and vice versa) there may occur symptoms of auditory aphasia. The aphasia produced by expanding lesions (tumors) is not as complete as is found in vascular lesions, except in the terminal stages of such a tumor. The aphasia usually takes the form of a depression of the ability to recollect names of persons, places, and things. Often such patients in ordinary conversation will show no particular speech defect, yet will make frequent mistakes when asked to name familiar objects, or to repeat certain sentences. The inability to name objects shown is due to an involvement of the association paths connecting the visual memory (angular gyrus) and auditory centers. When the lesion becomes very extensive, a complete auditory aphasia may result.

There are other neurological manifestations which may be present in temporal lobe tumors of either side which are caused by the pressure of the expanding lesions on neighboring structures. As the face centers

are located in the lower part of the precentral convolution just above the Sylvian fissure, a paresis of the facial movements on the side opposite the lesion may be present. This paresis is particularly marked when the patient smiles, (movements of emotion). Should the pressure upward be great, there may likewise be a certain amount of weakness of the movements of the arm and hand on the side opposite the lesion. Should epileptiform seizures occur, they usually consist of pronounced convulsive movements of the arm and face on the contralateral side. Should the lesion press upon the corona radiata there may be a contralateral hemiplegia.

The optic radiations in their course from the posterior part of the internal capsule to the occipital lobe run through the deeper portion of the temporal lobe; a not infrequent finding in temporal lobe tumors, therefore, is a left homonymous hemianopsia in a right sided tumor, and vice versa. In addition to the hemianopsia and sometimes in the absence of such, there may occur through irritation of the visual fibres, definite visual hallucinations. When these occur they usually assume a definite form and may be of persons or things, and practically always occur in the contralateral visual fields. For example, in one of my patients who had a large endothelioma of the right temporal lobe, there were attacks of visual hallucinations consisting of an automobile above the tree tops and always seen to the patient's left. Another patient with a right temporal lobe lesion has peculiar attacks during which she sees horrible faces to her left, accompanied by an odor of Hartshorn. During the attacks, which last only a few seconds, she can not see one's hand when held in the left visual fields.

Should the lesion be so extensive and deeply placed as to press on the corpora quadrigemina there will occur symptoms of unilateral involvement of these structures. These consist of a degree of deafness in the contralateral ear due to involvement of the subcortical auditory center which is located in the posterior corpus quadrigeminum, an ipsilateral cerebellar ataxia due to the close proximity of the superior cerebellar peduncle, and a contralateral homonymous hemianopsia due to involvement of the external geniculate body.

On account of the large so-called silent area in the right temporal lobe, tumors in this region may at times reach a very large size before giving rise to localizing symptoms or findings. The accurate localization in some cases can not be made without the use of ventricular air injection followed by X-Ray study.

(To be continued next month)



# Proceedings of The Seventy-Sixth Annual Meeting of Medical Association of Georgia Atlanta, May 13, 14 and 15, 1925

(Continued from October issue, page 439)

## MINUTES OF THE COUNCIL

The first meeting of the Council was held on Tuesday, May 12, 1925, at the Atlanta Biltmore, Atlanta, and was called to order at 6:45 P. M., by the Chairman, Dr. V. O. Harvard, of Arabi.

The Secretary called the roll and the following Councillors responded:

First District—C. Thompson, Millen.

Second District—C. K. Sharp, Alington.

Third District—V. O. Harvard, Arabi.

Fourth District—O. W. Roberts, Carrollton.

Fifth District—W. C. Lyle, Atlanta.

Sixth District—M. M. Head, Zebulon.

Seventh District—M. M. McCord, Rome.

Eighth District—H. M. Fullilove, Athens.

Ninth District—C. D. Welchel, Gainesville.

Tenth District—S. J. Lewis, Augusta.

Eleventh District—A. S. M. Coleman, Douglas.

Twelfth District—T. C. Thompson, Vidalia.

The Parliamentarian, Dr. Clark, and the Secretary, Dr. Bunce.

The Secretary then read the minutes of the last meeting of the Council, held on April 14, 1925.

Upon motion duly seconded and carried the minutes were adopted as read.

THE CHAIRMAN: Before taking up the regular business of the Council, gentlemen, we will consider the appeal of Dr. J. E. Woods.

DR. M. M. HEAD: I was at the meeting when this was first brought up and there was some doubt as to whether we could try this or not.

DR. M. A. CLARK: When was Dr. Woods a member?

DR. HEAD: Let us hear from Dr. Woods.

DR. J. E. WOODS: In 1917 I was a member in good standing of the Butts County Medical Society but carelessly neglected my dues until I was notified by Dr. Lyle. I at once turned the card over to my wife, who pays most of my bills, and she made a mistake of fifty cents in the check but this was mailed to Dr. Lyle and I received a receipt which Dr. Bunce has. He also has some letters. In 1919, I do not remember the exact time, I told my wife

to do the same thing, but happened to think to ask her how much she had sent before and she told me \$3.00. I told her it should have been \$3.50 and requested her to add fifty cents to this check to make up the full amount. I received a notice shortly afterward that I was suspended from the Society and would have to have the endorsement of two members before I could again become a member. In other words, that I would have to become a new member without having any hearing at all.

DR. CLARK: Why was the check sent to the State Society instead of to the County Society?

DR. WOODS: My wife just mailed it that way. The next year I told her to mail the check to the State Society to straighten out the amount I was short before. Dr. White received the check.

DR. CLARK: Did you pay your dues in 1917?

DR. WOODS: Yes, I have my fellowship card from the American Medical Association, or Dr. Bunce has it.

(Dr. Bunce presented these credentials.)

DR. CLARK: This card was sent to you by the Secretary of the State Association?

DR. WOODS: Yes.

DR. CLARK: In 1918 and 1919 to whom did you pay your dues?

DR. WOODS: I think to the local secretary. I do not remember just when but a short time after I received the notice. The check will show. I told my wife to add the fifty cents to the check in 1917 to make up the full amount of the year before, which was not enough.

DR. CLARK: Did you receive any statement from Dr. White?

DR. WOODS: I let it lapse for just a few months and then this check was returned to me with the statement that I was suspended and had to have the endorsement of two physicians for reinstatement, just the same as a new member. This without any hearing, but according to the By-Laws and Constitution every member is entitled to a hearing.

DR. M. M. McCORD: You were notified in 1919 that you had been suspended and you have not been a member since then?

DR. WOODS: Yes.

THE CHAIRMAN: Let us hear from Dr. White about this.



DR. WHITE: When I was Secretary of the Butts County Medical Society, Dr. Woods sent his check to the State Secretary, who was Dr. Lyle at that time. Dr. Woods was notified that his dues were \$3.50, \$3.00 to the State Society, and fifty cents to the County Society. When Dr. Lyle was notified of that fact, he returned the check to Dr. Woods. The way I see the matter, Dr. Woods has automatically suspended himself by not paying his dues. He has not paid any dues for seven years to the Butts County Medical Society.

DR. CLARK: Was this check sent to you? It is payable to you.

DR. WHITE: No, this check was sent to Dr. Lyle.

THE CHAIRMAN: Did he send it to you?

DR. WHITE: He may have, I do not remember. I do not think I have seen Dr. Woods in the Butts County Medical Society since he was a member. We elected him Secretary and Censor, but I do not think he attended a meeting once a year. He did not seem to manifest any interest in the Society and never did come, and he was automatically suspended. If Butts County Medical Society suspended him, I never knew it. I will read you what was said about it in the Butts County Medical Society. (Read letter). This shows that we deferred the matter and asked Dr. Woods to come and pay his dues and become an official member.

DR. CLARK: That says nothing about the dues, whether he did or did not pay them.

DR. WHITE: He has not paid any dues for seven years.

DR. CLARK: Dr. Woods says he sent this check to you, Dr. White, and that it was returned to him. What do you remember about that?

DR. WHITE: Dr. Woods never sent me that check so far as I can remember. We were lenient and treated Dr. Woods with every courtesy that we possibly could. During Dr. Elrod's term as Councillor we thrashed out this thing at our Sixth District Medical Society, when Dr. Thrash was President of the Association. When Dr. Elrod was Councillor he came over and we asked him to see Dr. Woods to see if he would come to the meetings and affiliate with us and make us an efficient member. I do not care to repeat what Dr. Woods said, but he told Dr. Elrod that he could tell the Butts County Medical Society to go to hell so far as he was concerned, that he did not care anything about it.

DR. CLARK: I hope you did not take his advice.

DR. WHITE: I did take his advice so far as he was concerned. We let him go his way and we went ours. We tried to do everything we could for Dr. Woods. I do not see that we have suspended Dr. Woods from the Society, but think he has automatically suspended himself.

DR. CLARK: You mean he is suspended until April first, but if he pays his dues within that year that reinstates him. On April 1, 1919, then, he was a member. (Read section of By-Laws concerning membership.) That is the reason why it is very important that we know about this. In 1918 we have evidence of membership. In 1919 if the dues are not paid by April 1st a member is automatically suspended. If he pays his dues any time during the year he is reinstated. Here is a check which Dr. Woods says he sent to Dr. White. If that is true he was a member at that time. Dr. Lyle is here and I will ask him to tell us about it, with the permission of the Chairman.

THE CHAIRMAN: We shall be very glad to hear from Dr. Lyle.

DR. LYLE: As I recall I did receive that check and this was not the first. He had sent me several checks with a statement to the effect that he would not pay his dues through the Butts County Medical Society, I returned check and told him that as there was a regular recognized medical society in Butts County I could not accept his dues unless they were paid in the usual way.

DR. CLARK: Do you recall whether the check was sent to you or to Dr. White?

DR. LYLE: No, I cannot say as to that for it was a long time ago.

DR. WHITE: Since Dr. Lyle made this statement it reminds me that he did send his check time and again to Dr. Lyle. I do not know why he did that.

DR. CLARK: You are sure he did not send you this check?

DR. WHITE: Yes, I am sure of that for I never received a check from him while I was secretary of the Society.

DR. HEAD: Do you remember ever writing him a letter notifying him that he was suspended?

DR. WHITE: No, I did not send him such a notice but he may have received a notice from the other secretary. I never received the check which you have here.

DR. WOODS: I am very sorry that the Doctor's memory is so poor. It would be strange if I was secretary and treasurer that I would not be present at the meetings. I am sure I was at the meetings. I am sorry I had to make such a remark as I did. One of the difficulties was that I had advised

the young daughter of one of my patients to ride horse-back, and soon afterward a paper was read before the Society stating what a disgrace it was for young ladies to ride horse-back. I could not see any harm in it and had advised her to ride horse-back because I thought she needed the exercise. I am sorry if I offended Dr. Elrod for it was not meant for him. As to the check, I cannot see why I should send Dr. Lyle a check made out to Dr. White.

DR. BUNCE: Can you identify this as a carbon copy of a letter which you wrote?

DR. WOODS: Yes, that is a carbon copy.

DR. WHITE: It was voted in our Society that each member should write an essay to read at the next meeting. I do not suppose Dr. Byron had any idea of Dr. Woods' patient riding but there was a great of comment in the paper about girls riding astride. I am sure Dr. Byron had no idea that Dr. Woods' daughter and his patient were riding horse-back at all.

DR. WOODS: In regard to the non-payment of dues since 1919, being a suspended member I could not be expected to pay. I think if you will investigate you will find that I pay my bills.

DR. FULLILOVE: Why did you not wish to get two members to endorse you?

DR. WOODS: I thought it was decidedly irregular. I had not received any hearing and I thought this was a little bit high-handed.

DR. HEAD: Who wrote you that you were suspended? Have you the letter?

DR. WOODS: No, I have not the letter. Dr. Lyle, do you remember that I sent you the letter with a check explaining about this?

DR. LYLE: No, I cannot remember that for it was a long while ago.

QUESTION: How did the check get back into your hands?

DR. WOODS: Dr. White returned it to me with a letter regarding my suspension.

DR. ELROD: In looking over the records I found that the transactions of 1907 show that Dr. Woods was a member of Henry County. In 1909 I found no record anywhere. The records of 1909 show him to be a member of Butts County, but the records evidently are wrong. The records state that he was there in 1907 and 1908 but did not pay his dues. The more recent Transactions show that he was admitted to Butts County in 1909.

DR. CLARK: In 1907 I was Councillor for Henry County. When I organized the Henry County Medical Society he joined. I organized the Henry County and the Butts County Medical Societies as Councillor for

the Sixth District. As Dr. Woods was nearer Jackson I encouraged him to join the Butts County Society. He was a member then. According to the By-Laws of the Association if this check was sent to the Secretary-Treasurer of the County Society in July, 1919, that should have reinstated him as a full member for 1919. They had no right to refuse the check and demand new membership. According to the By-Laws after one year's non-payment of dues you cease to be a member and have to join as a new member. This check was sent in July and should have been accepted. Any County Society member, according to our By-Laws, failing to pay dues by April 1st is automatically suspended. If during that time, no matter what his conduct may have been during that year—he may have been guilty of the grossest breach of ethics—he pays his dues that reinstates him. Then charges should be brought before the Association and dealt with accordingly.

DR. BUNCE: This copy has been identified by Dr. Woods as a carbon copy of a letter which he wrote. (Read the letter and one of August 13th.) I have another letter from Dr. Howell, the Secretary-Treasurer of the Butts County Medical Society, and also one from Dr. Hammond. (Read letters.)

DR. CLARK: My ruling would be that he has a right to appeal.

DR. HEAD: On my return home from Macon I wrote the Secretary of the Butts County Medical Society and also Dr. Woods asking them to try to get together and have a County meeting and we would ask Dr. Elrod to come over. I felt that it was a matter of all good fellows and that it should be straightened out. After that we had a meeting with a full attendance and Dr. Woods was there. I beat them all over there. Dr. Woods was probably ten minutes late coming in and when he came in not a Butts County man spoke to him. His talk that afternoon was as nice and pleasant as any man I ever saw. There is a feeling over there on both sides. Dr. Copeland got up and made a talk and said, "If the State Medical Society is going to poke this man down our throats the State Medical Society can go to hell, we won't have him." I would like to read a letter. Dr. White wrote Dr. Elrod he was glad this was coming up for that would give him a dose of the same medicine he gave us. That is a bad feeling on the part of Dr. White. I think Dr. White has absolutely forgotten that he received the letter and check for he certainly did that. (Read portion of letter received from Dr. Woods.) I will swear to you that I had the envelope with his name on it in which he sent the letter, to Dr. Woods.



DR. LYLE: If you will pardon me a moment I think perhaps I can throw some light on this. I will not be positive but it is my impression that Dr. Woods sent his check for \$3.00 to me in 1918. As you will recall, that was during the war, with secretaries absent and all that. I think his check was sent to me and that I sent him the eard in consequence of it. That check was for \$3.00 only. The next year, the check still being sent to me, I returned it with the statement that it must come through the County Society. I realize that there are two sides to the affair and as Dr. Head said there has been a feeling down there for ten years.

DR. HEAD: (Finished reading the letter).. I wrote to Dr. Woods and advised him as a gentleman and a man to put in his application and see if they would turn it down. This is not in reply to my letter advising this step. I tell you, gentlemen, there is a little snake in the grass there on both sides. I think Dr. White's memory has escaped him on this matter. I have thought the thing over seriously. My first knowledge of this—I'll tell you now I beat all the doctors over to Jackson by about an hour and went to the Clerk of the Court and to the Sheriff and to two or three mercantile houses and asked about Dr. Woods. Mr. Foster, the Clerk of the Court, said they had not a better doctor or a nicer man in Butts County. I told him about the matter and he said he had heard of it and it was nothing but prejudice. He said, "He does more work than any of the other men over there. He is a smooth proposition." Dr. Aiken I think would like to see him back in the Society. Dr. Howell said, "I am a young man and a member of the Society, but there are men right here who have done worse than Woods," and he moved to take him back.

DR. ELROD: Dr. Head got that statement just a little wrong. Copeland read the section in the Constitution and By-Laws in regard to a member having an appeal and stated that he did not see where Woods had an appeal, that he was not a member, having automatically been dropped for the non-payment of dues, and said "If the Council of the Medical Association of Georgia wants to put him on us we will hunt up our Charter, if we can find it, and send it back to them for we do not care for him as a member, unless he will come back as a new member with two men to recommend him, and that will have to lie over for six weeks."

DR. HEAD: Dr. Clark has asked me what I would recommend. I do not see how we can recommend anything except to take him back. I really believe he should be in the Society. I believe the Society will do

him good and that he will not do the Society any harm. I hate to see the Society torn up over there and it might do that if we do not handle the matter with a great deal of tact. They have a personal feeling over there that is not an ethical feeling.

DR. ELROD: They feel that Woods is continually doing things that are unethical. They continually bring that up and they cannot get Woods to ask any forgiveness for anything he has done. He made the statement that afternoon that he did not care anything about the Society at the present time but asked that justice be done an innocent party, meaning Dr. Hammond.

DR. CLARK: Is he a perfectly ethical man over there?

DR. HEAD: I do not know whether he is or not but I think he is as ethical as any of them.

DR. CLARK: There is one mistake that Dr. Woods has made. He should have sent the Secretary his check every year since 1919 and then he would be in good standing. If I got careless and did not send my dues in I would not be eligible to the benefits of the Society, but any time during the year that I send a check that reinstates me. As he did not send a check for 1920 he was automatically dropped and the year of 1920 he was still dropped. There is human nature in that. Would any of you have sent yours? I would not have sent mine for I would have been sure they would have returned it. He has a strong case and you want to go into it very carefully and very wisely and very discreetly. They have allowed human nature to enter into it so far that they have forgotten human kindness. Dr. Woods does the larger part of the work in the County. When they would not consult with him he encouraged this other man to come in. I do not blame him for that for he needs help at times. I am satisfied that Dr. White received this check. There was a blunder on the part of the Society and that blunder caused all the other blunders. I believe legally if Dr. Woods will tender his dues from 1919 there is no reason why they should not accept him.

DR. T. C. THOMPSON: Dr. White said he never had been in harmony with the Society nor attended it once a year. So far as the public is concerned, if one man pulls away from the County Society the public will go with him. It seems to me this man feels himself bigger than the Society and does not want to abide by the rules of the Constitution and By-Laws and that will tear up the whole Society if we do not mind.

DR. C. THOMPSON: It seems to me the whole business is to be settled out of court,



if at all. You have not settled it with Dr. Woods or the other men. It seems to me Dr. Head's suggestion is the only possible solution. If Dr. Head and Dr. Elrod and Dr. Clark, for instance, can get these men together and get their hearts right the thing will be settled.

DR. CLARK: I think Dr. Head's suggestion is good but we could not expect Dr. Woods to send in his application when he is certain they will refuse it. We need missionary work on both sides. So far as the Society is concerned, the Medical Association of Georgia is better off without them than to have them bringing the Society into disrepute as they are doing. I was up there some time ago and talked about it to one of the doctors and they entertain and he showed a good deal of feeling. He claimed this man had consulted with a man who was not a member of the Society. If all of us consulted with nobody but members it would be a difficult thing. If I can be of any help in the missionary work I shall be glad.

DR. C. D. WHELCHEL: According to the By-Laws a man is suspended if his dues are not paid by April 1st. He suspends himself and reinstates himself in this way. The interesting thing is that there are seven or eight members of the Butts County Medical Society. Why is it that Dr. Woods cannot get two men to recommend him?

THE CHAIRMAN: I think he can. There are two men who are willing to have him back.

DR. WHELCHEL: If they are censors and bring up his name can he be turned down by his County Society?

THE CHAIRMAN: If the majority vote against him he can.

DR. S. J. LEWIS: I am not exactly clear as to this gentleman's status. Is it a question of his non-payment of dues or is it a question of jealousy existing in the County?

THE CHAIRMAN: They claim it is non-payment of dues. He claims that he tendered his dues and they were not accepted. He has the returned check and correspondence to back his check.

DR. LEWIS: If it is a question of his dues the Society can accept them, but if it is a question of jealousy I do not see what we can do.

DR. M. M. McCORD: This is to decide the legal side of the question. We cannot decide about the local conditions down there. Dr. Head and Dr. Elrod and Dr. Clark can go down there and see to things if they wish but I see nothing for us to do except to abide by the decision of our Parliamentarian which is that since Dr. Woods tendered his check in 1919 if he tenders his dues for the

remaining years that will restore him to membership.

DR. C. K. SHARP: It looks as if we had to clear the stream before we can do anything. I do not see any chance to do anything unless we can effect a reconciliation on both sides. As Dr. Head says, this must be done with a good deal of tact. It has to be done largely by the local society itself and suggestions from the Council may make bad matters worse.

DR. LYLE: I want to respectfully ask, in order to expedite matters—I think we all understand what the situation is and that we cannot handle it yet; we are likewise agreed that there must be some effort at reconciliation. I wish to make a motion that the matter be referred to a committee consisting of Dr. Elrod, Dr. Clark and Dr. Head to report back at the next meeting of the Council.

DR. CLARK: The facts, according to our By-Laws, are that Dr. Woods tendered his dues in 1919. The Secretary of the Society refused them. The Society was in error in refusing those dues. Dr. Woods did not tender dues after 1920; therefore, according to our By-Laws he was dropped and is not a member and has not been a member since then. Also according to the By-Laws the only way for him to again become a member is by making application as a new member. It is not our duty to go into it. The Society was in error when his dues for 1919 were refused and Dr. Woods was in error since he did not tender his dues for 1920.

DR. HEAD: I think Dr. Lyle could have a second to his motion and we can get together and talk this over and bring in a report tomorrow. I will second his motion.

DR. C. THOMPSON: I will amend Dr. Lyle's motion to table this matter until Dr. Clark, Dr. Elrod and Dr. Head see what they can do.

DR. LYLE: If he did not pay his County Society dues they had a right to drop him.

DR. O. W. ROBERTS: The County Society is the thing that is dependent upon the dues for its own existence and to my mind we should go very slowly in doing anything against a County Society. According to our By-Laws I do not see how you can have a member lapsed except in one way. To reinstate a man who has been suspended in that way I think would be a dangerous thing to do against the County Society. What is the excuse for the dues not having been paid in 1920 and 1921? I do not know any law that would excuse a man for not paying his dues in those years. Since they have lapsed it seems to me the only thing to do is to have him join as a new member. I think there are big enough men in that

County to straighten it out and I do not think we can straighten it for them. I think if Dr. Woods joins just like any other man has to do and then comes into the State Society that is the proper thing. It is for us to decide and the facts lie here. They have been working on it for a long time and some have been on the Council a great deal longer than I have.. I just want to abide by the Constitution and By-Laws and take care of the County Societies as well as the State Association.

DR. FULLILOVE: If you had belonged to the Society and they threw you out, and you knew they would not accept your application, would you put your application in?

DR. ROBERTS: I would not expect anybody else to do it for me.

Dr. Lyle's motion was put to a vote and carried.

THE CHAIRMAN: We will now have the report of the Committee on Publication if it is ready.

In the absence of Dr. Charles Usher, Chairman, Dr. J. W. Palmer presented the following report:

#### REPORT OF COMMITTEE ON PUBLICATION.

Your Committee on Publication submits the following report of its work for the year 1924-25:

This Committee, together with the Secretary-Treasurer, Business Manager of the Journal and Executive Secretary, has had charge of the publication of the official Journal, under the direction of the Council. We have outlined the scope of the Journal as follows:

1. To publish the minutes of each annual meeting and transactions of the House of Delegates.

2. To publish all papers read at the annual meeting, as provided in the Constitution and By-Laws, together with discussions as transcribed by the official stenographer and corrected by the members giving the discussions.

3. To publish reports of the annual meetings, giving names of officers and proceedings of each county and district society and such other reports from county societies as provided in the Constitution and By-Laws.

4. To publish news items sent in by the secretaries of county societies, individual members and as obtained from a clipping bureau after being checked up as to the membership of the doctors concerned..

5. To publish the selected papers from district and county societies when there is

room and when such papers are submitted in proper form for publication.

6. To publish papers submitted by individual members when such papers are suitable for publication and when there is sufficient room in the Journal.

We recommend the following regulations in reference to publication of all papers in the Journal:

1. Members are to be in good standing in order for their papers to be published in the Journal.

2. All papers submitted for publication must be typewritten, double-spaced, written on one side of paper and must be reasonably correct from standpoint of spelling, capitalization, punctuation, grammar and rhetoric.

3. Illustrations will be published when submitted with paper, provided they are in proper form. However, all illustrations and cuts shall be paid for by contributors and not by the Journal, since we have no fund available for this purpose.

During the year, we have published 94 original articles contributed by 88 members. An effort has been made at all times to give as wide a representation as possible.

We are pleased to report that there is no longer any difficulty in securing excellent material for the Journal. Many more articles are submitted than can be published. We are also pleased to note that there has been a decided improvement in the character and composition of articles submitted for publication. However, we respectfully suggest that the secretaries of district and county societies submit only articles which comply with the above regulations for publication.

Respectfully submitted,  
COMMITTEE ON PUBLICATION.

Chas. Usher, M.D., Chairman.

S. J. Lewis, M.D.

T. C. Thompson, M.D.

On motion duly seconded and carried the report was adopted as read.

(To be continued in next issue)

#### PHYSICIANS WANTED

**Physician wanted.** Death of last incumbent has left vacant a location. Ten miles south of Quitman. Has supported a physician for past forty years. Address William Barrs, Quitman, Georgia, Route 3.

**Physician wanted** at Moreland, which is located about 35 miles below Atlanta. Address B., care the Journal.



# Medical Association of Georgia

Next Annual Meeting, Albany, Ga., May 12, 13, 14, 1926

President-----	Frank K. Boland, Atlanta
First Vice-President-----	W. R. Dancy, Savannah
Second Vice-President-----	H. M. Fullilove, Athens
Secretary-Treasurer-----	Allen H. Bunce, Atlanta
Parliamentarian-----	M. A. Clark, Macon
Delegate to A. M. A. (1925)	
A. H. Bunce, Atlanta	
Alternate, W. C. Lyle, Atlanta	
Delegate to A. M. A. (1926)	
R. L. Miller, Waynesboro	
Alternate, C. W. Roberts, Atlanta	

## COUNCIL

V. O. Harvard, Chairman-----	Arabi	Allen H. Bunce, Secretary-----	Atlanta
------------------------------	-------	--------------------------------	---------

### Councillors

1. Chas. Usher (1927)-----	Savannah
2. C. K. Sharp (1927)-----	Arlington
3. V. O. Harvard (1927)-----	Arabi
4. O. W. Roberts (1927)-----	Carrollton
5. E. C. Thrash (1928)-----	Atlanta
6. M. M. Head (1928)-----	Zebulon
7. M. M. McCord (1928)-----	Rome
8. Stewart D. Brown (1928)-----	Royston
9. C. D. Wheelchel (1926)-----	Gainesville
10. S. J. Lewis (1926)-----	Augusta
11. A. S. M. Coleman (1926)-----	Douglas
12. T. C. Thompson (1926)-----	Vidalia

### Vice-Councillors

1. C. Thompson (1927)-----	Millen
2. R. F. Wheat (1927)-----	Bainbridge
3. J. F. Lunsford (1927)-----	Preston
4. J. A. Thrash (1927)-----	Columbus
5. W. A. Selman (1928)-----	Atlanta
6. J. M. Anderson (1928)-----	Barnesville
7. J. H. Hammond (1928)-----	LaFayette
8. B. C. Teasley (1928)-----	Hartwell
9. W. J. Hutchins (1926)-----	Buford
10. H. D. Allen, Jr. (1926)-----	Milledgeville
11. K. McCullough (1926)-----	Waycross
12. J. Cox Wall (1926)-----	Eastman

## COMMITTEES

### Committee on Scientific Work

W. A. Mulherin, Chairman (1926)-----	Augusta
Frank Bird (1926)-----	Valdosta
A. H. Bunce, Secretary-Treasurer-----	Atlanta

### Committee on Public Policy and Legislation

J. W. Palmer, Chairman (1926)-----	Ailey
W. E. McCurry (1927)-----	Hartwell
B. H. Wagnon (1928)-----	Atlanta
Frank K. Boland, President-----	Atlanta
Allen H. Bunce, Secretary-Treasurer-----	Atlanta

### Committee on Medical Defense

M. A. Clark, Chairman (1928)-----	Macon
E. C. Thrash (1926)-----	Atlanta
E. C. Davis (1929)-----	Atlanta
V. O. Harvard, Chairman, Council-----	Arabi
Allen H. Bunce, Secretary-Treasurer-----	Atlanta

### Committee on Hospitals

C. Thompson, Chairman (1926)-----	Millen
R. M. Harbin (1926)-----	Rome
W. H. Myers (1926)-----	Savannah

### Committee on Necrology

L. A. Baker, Chairman (1926)-----	Tifton
L. M. Gable (1926)-----	Griffin
W. H. Clark (1926)-----	LaGrange

### Committee on Health and Public Instruction

Theo. Toepel, Chairman (1926)-----	Atlanta
H. B. Neagle (1928)-----	Augusta
J. A. Thrash (1927)-----	Columbus
Frank K. Boland, President-----	Atlanta
Allen H. Bunce, Secretary-Treasurer-----	Atlanta

### Cancer Commission

J. L. Campbell, Chairman-----	Atlanta
Chas. Usher-----	Savannah
C. H. Watt-----	Thomasville
G. Y. Moore-----	Cuthbert
Frank P. Norman-----	Columbus
A. R. Rozar-----	Macon
W. H. Lewis-----	Rome
J. S. Stewart, Jr.-----	Athens
M. B. Allen-----	Hoschton
E. A. Wilcox-----	Augusta
H. M. Branham-----	Brunswick
T. C. Thompson-----	Vidalia

### Committee on National Defense

1. R. E. Graham-----	Savannah
2. H. M. Moore-----	Thomasville
3. Job. C. Patterson-----	Cuthbert
4. W. F. Jenkins-----	Columbus
5. R. R. Daly, Chairman-----	Atlanta
6. Linwood M. Gable-----	Griffin
7. Chas. V. Wood-----	Cedartown
8. Eugene F. Griffith-----	Eatonton
9. John K. Burns-----	Gainesville
10. Francis X. Mulherin-----	Augusta
11. G. T. Crozier-----	Valdosta
12. Ovid H. Cheek-----	Dublin

### Fraternal Delegates to Other State Meetings

To Visit Florida: B. H. Minchew, Waycross;
Geo. L. Touchton, Savannah.
To Visit South Carolina: E. E. Murphey, Augusta;
B. C. Teasley, Hartwell.
To Visit Alabama: J. M. Anderson, Columbus;
J. W. Landham, Atlanta.
To Visit Tennessee: H. L. Erwin, Dalton; J. H. Hammond, LaFayette.
To Visit North Carolina: J. H. Downey, Gainesville;
C. L. Ayers, Toccoa.



# Woman's Auxiliary of the Medical Association of Georgia

## OFFICERS

President ..... Mrs. William H. Myers, Savannah    Secretary-Treasurer, Mrs. A. J. Mooney, Statesboro  
Vice-President-at-large, Mrs. C. W. Roberts, Atlanta    Parliamentarian, Mrs. Allen H. Bunce, Atlanta

# FOX & WEEKS

## Ambulance Service

### Savannah, Ga.

## Syringe Sterilizers

### Sterilization Without Trouble



This fine little ideal syringe sterilizer is designed for office use.

It is made through out of seamless white enamel ware and has a removable perforated holder for 10, 5 and 2cc. syringes and four needles.

Complete as illustrated. 2CJ9309. Syringe Sterilizer, **\$3.75**

*Mail This Coupon*

**FRANK S. BETZ COMPANY** 634 South Wabash Ave.  
Hammond, Indiana Chicago, Illinois

Enclosed please find \$3.75 for which you may send me one 2CJ9309 Syringe Sterilizer under your unconditional guarantee.

Name .....

Address .....

City..... State.....

## SPENCER REJUVENO

### SURGICAL SUPPORTS

*"We Create a Design Especially for You"*

Let us demonstrate the truth of the above by handling a test case for you. Graduate designers.



*Prescribed by leading physicians.  
Endorsed by best-known hospitals.*

It is a non-elastic belt made for women and men and is particularly adapted for those having hernia, enteroptosis or obesity, pregnancy, sacroiliac sprain. It gives perfect support with greatest freedom of action. A perfect support following surgical operations.

Gives all the ease of the uncorseted figure, but prevents fatigue by supporting abdomen and back.

**MRS. FRANK HAMES**

District Manager

44 S. Howard St.

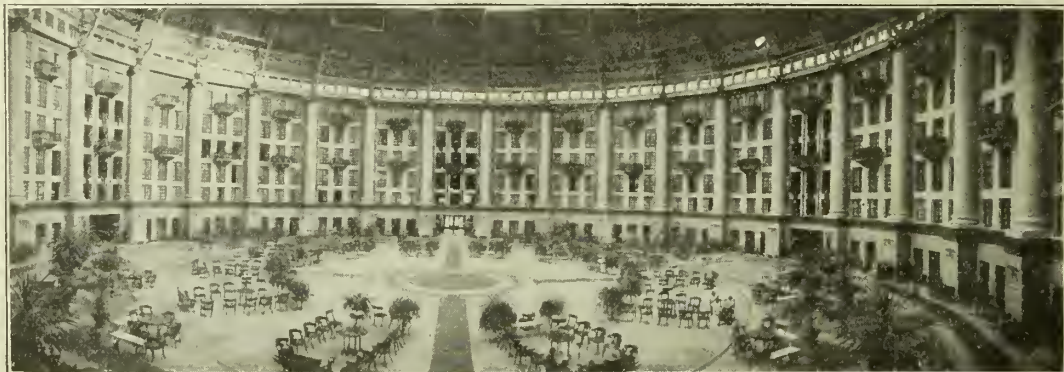
Dearborn 2222

ATLANTA, GEORGIA

# A Complete Hospital

IN A

## Famous Health Resort



*Pompeian Room of West Baden Springs Hotel—200 Ft. in Diameter*

### WEST BADEN SPRINGS, INDIANA

*The Carlsbad of America*

THIS famous spot in the foothills of the Cumberland Mountains offers the rare combination of a pleasure resort with a special department providing every modern facility for medical or surgical treatment. The physician or his patient will find at West Baden Springs Hotel whatever diversion, recreation, medical supervision or treatment may fit his needs or desires.

#### *Keeping Well Is Much Easier Than Getting Well*

Periodical physical examinations—a careful checking up on the condition of the human body—is the modern and the economical method of prolonging life and enjoying good health. Health can be repaired more quickly in surroundings that are attractive and congenial like those at West Baden Springs Hotel. It com-

bines the charm of a famous resort with the most modern medical and hospital appliances where any needed physical reconstruction may be given without the severance of family ties. The equipment includes X-Ray and Physiotherapy departments and important Chemical and Bacteriological Laboratories.

#### *Medical and Surgical Facilities*

The Medical and Surgical Departments occupy the top floor of the West Baden Springs Hotel; and while an integral part of the Hotel, they are a separate institution and under individual management. Physicians of recognized ability, technicians, nurses and dietitians are in atten-

dance, also graduates masseurs from Carlsbad, Austria. The Medical and Surgical Departments have been planned so as to give personal and individual attention to each patient. All baths, including the well known hot sulphur mud baths, are under the supervision of the Medical Staff.

#### *West Baden Springs Hotel*

This is an ideal place for rest and recreation. It is located in the charming Lost River Valley of Southern Indiana in almost the exact center of the population of the United States. It is easily accessible from the large centers in any direction, and is a delightful place to stay under any condition. The 700 bedrooms are modern,

the cuisine excellent, the sports diversified, the atmosphere enjoyable the year round. The waters of West Baden Springs are nature's own remedy. The four springs, including the Famous No. 7, are located near the hotel. COME to West Baden Springs Hotel to ENJOY AND PROLONG LIFE.

*Write for particulars regarding rates, reservations and other information on Medical and Surgical Departments to*

C. W. DOWDEN, M. D., F.A.C.P., Med. Dir.

G. P. GRISBY, M. D., F.A.C.S., Surg. Dir.

**WEST BADEN SPRINGS HOTEL,**  
West Baden Springs, Indiana

# THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL PROFESSION OF GEORGIA  
PUBLISHED MONTHLY under direction of the Council

Volume XIV

Atlanta, Ga., December, 1925

No. 12

## Original Articles

### INTRACRANIAL INJURIES IN THE NEWBORN\*

C. H. Richardson, Jr., M.D.  
Macon, Ga.

A plea for the stillborn infant and those dying in the first few days of life is the writer's excuse for presenting for your consideration certain facts which have appeared in medical literature for many years, but which have only been duly appreciated in the last decade.

The obstetrician has apparently failed to realize his responsibility in the matter, and it is probably true that in a large number of cases today definite signs of intracranial birth injuries are overlooked, and are only suspected months and years later if the hemorrhage has not been entirely absorbed. We cannot expect marked improvement until the obstetrician is fully impressed with the importance of giving careful thought to the prevention of these injuries, and the obstetric routine includes a careful examination of the newborn and observation of his behavior during the first few days of life.

In discussing the rather broad field of intracranial injuries in the newborn in the limited scope of this paper I shall confine myself to those that are the result of the trauma of birth and which result in intracranial hemorrhage, as it is obvious that all severe injuries of the cranial bones and their contents will be measured by the increase in intracranial tension which is produced.

The frequency of the condition and the far-reaching significance of its effects have been brought to our attention by the patholo-

gists in the results of a large number of routine autopsies on infants dying in the first few days of life. Bailey in 1920 in 100 autopsies in the Manhattan Maternity in New York found intracranial hemorrhage in 40 cases, and Rodda in the same year at the Newborn Clinic of the University of Minnesota revealed the fact that more than 50 per cent of all infants that die intrapartum or during the first few days of life, even after easy delivery, but frequently after breech and premature labors, have succumbed to intracranial hemorrhage. Sharpe has shown an even more pertinent fact; in 100 consecutive deliveries at the City Hospital, New York, in which routine lumbar puncture was done in twenty-four to forty-eight hours after birth, evidence of blood in the spinal fluid was found in 10 per cent. The clinical symptoms in some of these would have passed unnoticed but for the examination.

The pathologists have taught us another interesting fact, that the lesion which produces intracranial hemorrhage in the newborn is a venous injury, and not as formerly thought a rupture of cortical veins, but rather an injury of the tentorium cerebelli accompanied by rupture of venous channels that lie in and adjacent to it. In order to have an understanding of the nature of these injuries it is necessary to review the anatomy and function of the tentorium, that fold of dura mater which lies between the cerebellum and the cortical hemispheres, and the

\*Read before the Medical Association of Georgia, May 13, 1925.



falx cerebri whose lateral extensions divulge to form the upper layers of the tentorium. The longitudinal direction of the fibers in the falx and their lateral extension in the tentorium, would seem to indicate that it is the chief mechanical task of these structures to prevent excessive lateral compression of the skull which is apt to occur during molding. When this compression is extensive or severe these structures become overstretched and tears occur in the weakest points which are in the lateral fibers of the tentorium. Hence, it is rather generally agreed that intracranial hemorrhages of clinical importance in the newborn are most often situated just above or below the tentorium and for all practical purposes these hemorrhages may be divided into supratentorial and infratentorial types, and naturally often the types are mixed. Undoubtedly hemorrhages into the brain substance and lateral ventricles do occur, but they are rare and need only be mentioned in passing. Hemorrhages also occur in the subarachnoid spaces but they are usually slight and disappear without notice unless the infant has a delayed coagulation time and the hemorrhage is progressive. It is the dural hematomata divided into the supra and infratentorial types above that represent from a practical point of view the most important group of intracranial birth hemorrhages.

Sharpe states that it seems to be the consensus of opinion among investigators that the cause of this condition can be attributed to one of the following main groups or a combination of them: First, Trauma; second, Asphyxia or congestion; third, Blood disease of the newborn. Ehrenfest groups them as immediate, predisposing and contributing causes.

In both classifications the mechanical nature of the injury is obvious, and stands out as the prominent etiological factor.

In every normal labor there is necessarily a definite compression of the fetal skull with reduction in volume, and if this compression takes place gradually and is not excessive the cranial cavity can accommodate itself to the change by allowing the cerebrospinal fluid to escape into the spinal canal and by a reduction of blood volume in the brain. Also in the process of molding lat-

eral compression occurs with a necessary lengthening of the antero-posterior diameter of the skull. When this lateral compression becomes excessive or is too prolonged the tentorium is put on excessive strain and rupture is apt to occur. It can also be seen that sudden or quick compression, as occurs in a rapid or precipitate labor and which does not allow time for molding, and in which the fetal head cannot adapt itself to the tremendous force of the uterine contractions, or in the forced passage of the head thru the undilated cervix, or over a rigid and unyielding perineum, is fraught with much danger to the delicate blood sinuses of the fetal cranium. Hence it would seem that the injudicious use of pituitrin may be a potent factor in the production of these injuries as its action tends to bring about the very conditions which predispose to these injuries.

It is undoubtedly true that the improper use of forceps has played a very important role in the production of these injuries but it is also true that too important a role has been attributed to this instrument as more recent statistics show that they occur with almost equal frequency in normal and spontaneous deliveries and that they have occurred in Caesarean sections. This is no argument however for the careless use of forceps and if we are to bring about a reduction of these injuries, part of which are unavoidable, there must be a limitation of the number of forcep applications.

The immediate infant mortality in cases of high forceps has been estimated as between 43 and 50%, and it would seem that in the interest of the child this operation had better be abandoned whenever possible. There is little doubt that the necessity for instrumental delivery is often carelessly determined and not always executed with the least risk to the child.

It has been shown that in breech labors when the occiput is forcibly pressed against the symphysis and the cerebellum pushed up against the tentorium, the latter may rupture and intracranial hemorrhage result. Naturally, the danger of this is very much increased by violent efforts at delivery. The congestion which results in the venous channels of the cranium also contributes to the

likelihood of rupture. As it has been shown that the infant mortality of breech labors is in general about 15% it is obvious that an effort to diagnose and correct this malpresentation by external version before labor begins would contribute to a lowered incidence in the production of birth injuries.

Syphilis, prematurity and asphyxiation may be mentioned as predisposing causes and the possibility of the latter should always be kept in mind and determined by careful and frequent auscultation of the fetal heart sounds. When these tend to become slower and slower as labor progresses it is evidence that the congested vessels of the cranium are being subjected to severe strain and all efforts consistent with safety should be made to terminate labor.

It should also be remembered that apparent asphyxia at birth may in reality be the evidence of an intracerebral injury that has already occurred and the condition may be made very much worse by violent effort at resuscitation. Such efforts are rarely justifiable, and in the presence of an intracranial injury, may be the means of converting a mild hemorrhage into a very severe one.

Another condition which may contribute to these injuries is a hemorrhagic diathesis, or a delayed coagulation time which often occurs in the newborn. The normal clotting time in the newborn has been shown to be from five to nine minutes, while in infants with a hemorrhagic tendency it will be found to be from eleven to thirty-two minutes. This is not only a factor in the production of hemorrhage but tends to favor its increase once it has occurred.

It is seen that the outstanding cause of intracranial injuries in the newborn is mechanical trauma which occurs in anomalous conditions of labor, such as difficult forcep extractions, breech labors, all conditions of dystocia, etc., and that this same trauma is exerted in normal labor when the uterine force is excessive, or rendered so by such agencies as pituitrin; when labor is prolonged, and that the premature infant or the one with a hemorrhagic tendency is more susceptible to this trauma.

The occurrence of intracranial hemorrhage naturally manifests itself in the symptoms of intracranial hypertension and while

there is some similarity to the classical signs which occur in the adult skull, yet the anatomic difference in the two produce a certain dissimilarity in symptoms. The appearance of the infant at birth is striking and very important, and the presence of marked asphyxiation should always suggest the possibility of an intracranial injury. If these infants react and survive the first few hours of life the signs of cerebral irritation occur. Restlessness is accompanied by incessant crying, and the infant refuses to nurse due to the absence of the normal sucking reflex.

The classical symptoms of intracranial hypertension in the infant usually appear as bulging and tenseness of the anterior fontanel and this is usually followed by convulsions which may appear as twitching of certain groups of muscles, rolling of the eyeballs, strabismus, and then becoming more generalized and frequent, and finally resulting in the fatal cases, in paralysis, coma and death.

To appreciate and understand more clearly the meaning of the symptoms as they appear we must go back to our classification of these hemorrhages into the supratentorial and infratentorial types, for in the former we have a cortical hemorrhage and in the latter a basilar one. If the hemorrhage occurs above the tentorium the effused blood rises upwards and spreads over the convolutions of the cerebral hemispheres and we have the picture of hemispheric compression developing relatively slowly. The infant in appearance is apt to be pale, cries a great deal, refuses to nurse, twitchings and paralysis of various muscle groups appear as their centers are compressed, reflexes are apt to be increased, **bulging of the fontanel** occurs and if the compression is progressive, paralysis and coma supervene, and death occurs, though later than in the infratentorial type. On the other hand if the hemorrhage occurs below the tentorium the effusion is immediately poured out around the vital centers in the medulla and we have a more rapid and serious picture. In the foreground of all symptoms due to infratentorial hemorrhage stands impairment of respiration. These infants are apparently asphyxiated at birth and remain cyanotic, they are quiet, show few symptoms of cortical irritation,



and signs of hypertension appear later if the infant survives. In this type of injury death occurs early, usually in twenty-four or forty-eight hours.

These are the symptoms in the severe cases which are usually easily recognizable, but we must not forget the mild cases, where only the slightest signs are present, such as an occasional muscular twitch, poor nursing, slight drowsiness, a weak cry, poor color, cyanotic tinge, the failure to use certain groups of muscles or slight palsies. For these are the ones which if unnoticed, and there is a failure of clot absorption, later contribute to the ranks of the backward, the feeble-minded and the epileptics. If we are to diagnose these mild cases, we must suspect intracranial injury in all cases of prolonged and difficult labor, and it is in the mild cases that its recognition is so important. In the severe cases the diagnosis is much easier and the infant at birth is seemingly in a state of deep asphyxiation; it cries little at first and much later, nurses poorly, often shows signs of external trauma, and later develops signs of intracranial hypertension. An examination of the eyegrounds reveals retinal hemorrhage, inequality of the pupils and a blood examination may show a delayed coagulation time.

Probably the most valued diagnostic aid at our command is lumbar puncture and the finding of blood in the spinal fluid is pathognomonic. This simple procedure should be used early in every suspected case as it is valuable not only in diagnosis but in the treatment of these conditions. Of course it is not entirely free of danger but the writer has used it numbers of times in the newborn and has never seen the slightest ill effects. On the other hand such marked improvement often follows the repeated withdrawal of bloody spinal fluid that it has seemed the most valuable agency not only in diagnosis, but in treatment.

Naturally, the outcome in these cases depends upon the extent and location of the hemorrhage. If the effusion is excessive, particularly if of the infratentorial type and is poured out around the centers in the medulla death supervenes early. These cases are deeply cyanosed and never react.

If the hemorrhage is cortical and is progressive and cerebral compression proceeds to the stage of convulsions, which occur in rapid succession the prognosis is decidedly unfavorable. If these cases survive they frequently join the ranks of the spastic paralytics later on, the mental defectives and the epileptics. The question of epilepsy and hydrocephalus developing later in childhood as a result of intracranial birth injuries is a mooted one but the evidence seems to be accumulating to support these contentions.

We have seen that these injuries are more common than generally recognized, that they may appear early with overwhelming signs and proceed to a rapid fatal issue, and that on the contrary they may appear late, several days after birth with indefinite signs which may be so mild as to go unnoticed and the possibility of their presence should always be suspected, and diagnosis made early for treatment to be effective.

The most adequate treatment of these injuries lies in their prevention. This is not always possible, but in all probability the greatest advance in preventive medicine in the next decade will relate to the care of the child-bearing woman and the newborn infant. The obstetrician must realize and accept his responsibility, and must have at his command the alert judgment and knowledge which thorough study of his art affords. He must not allow haste to prompt the use of injudicious measures, but he must be keen enough to detect the signs when nature falters and courageous enough to promptly take command and terminate a situation which is becoming dangerous to both mother and baby. Having done all of these things he will still be occasionally confronted with the signs of an intracranial injury and careful observation and early detection will make possible early rational treatment when it will be most efficacious.

As stated above, the most valuable diagnostic aid at our disposal is lumbar puncture, and we may add here that it is also probably our most efficient therapeutic agency. The repeated removal of from five to twenty c.c. of bloody spinal fluid at from twelve to twenty-four hour intervals, depending upon the extent of the intracranial extravasation is often attended by the hap-



piest and most surprising results. Improvement in the general conditions is often immediate and permanent. These taps may be repeated for several days until signs of cerebral compression no longer occur.

Certain symptomatic treatment is of value and certain protective measures should be applied in all cases. The infant is moved and manipulated as little as possible and kept in a quiet darkened room and protected from all irritation. If unable to nurse it should be fed with a large medicine dropper and if unable to swallow thru a nasal tube. Bromides are given for twitchings or convulsions, and if there is delayed coagulation of the blood an intramuscular injection of blood may be given into the buttocks or better still a transfusion of whole blood given into the longitudinal sinus.

Sharpe and others have suggested modified subtemporal decompression and cranial drainage in cases where lumbar puncture fails.

All measures at our disposal are worthy of careful trial for often times the most apparently hopeless cases make a speedy and apparently complete recovery.

#### Discussion on Paper of Dr. C. H. Richardson, Jr.

DR. W. A. MULHERIN, Augusta, Ga.: I think this is a very important subject. At times we blame the obstetricians too much for cerebral hemorrhages. We have to consider first that the baby is predisposed to hemorrhage because of the overlapping of the cranial bones. There is a tendency in some children to bleed, and while the forceps do some harm I think very often the obstetricians are not to blame.

One point I think should be stressed, and that is that if the child does not nurse the mother's breast the bleeding and coagulation time should be taken. Why? Because in hemorrhagic disease of the new-born this is an early symptom. Hemorrhage frequently is due to the absence of some substance in the blood, which permits the cerebral hemorrhage. If these are taken early and the bleeding time is found to be thirty or forty minutes you know you have a hemorrhagic child. If you give the mother's blood simply take it in a syringe and put it under the skin and repeat the injection as needed. This will often save the child's life.

As to spinal puncture, I have seen many instances where I could not find blood in

the spinal fluid. It does relieve tension and often prevents the after-effects that are so sad for any young child. The child with the cerebral paralysis is often better off dead than alive, with the very sad after-effects.

DR. ALLEN R. ROZAR, Macon, Ga.: Two cases have recently come under my observation in which the labor was almost absolutely normal, but the child had cerebral hemorrhage. This is more often due to some defect in the child, either in the clotting time or to some cerebral defect in the vessels, than to the pressure exerted during delivery. I think this is more often the cause than the prolonged and difficult labor.

DR. H. P. HARRELL, Augusta, Ga.: I wish to say a word about the method of obtaining the coagulation time in these children. I am connected with the University Hospital in Augusta and it has been our custom to do this on all new-born infants. I think it very advisable, especially in the hospital. The method we have been using is the watch glass method, and the technique is as follows: Two watch glasses are used and the blood is obtained by sticking the heel of the infant with an ordinary writing pen point, the drop of blood is touched with the concave surface of the watch glass, and covered at once with the other watch glass. By this means evaporation is done away with, and by uncovering and running at intervals the pen point through the drop of blood, one can get a pretty good idea of the coagulation time. We have found the coagulation time to average around eight minutes. If one uses the ordinary glass slide the evaporation is so rapid that one cannot get a very accurate idea of the coagulation time.

DR. M. HINES ROBERTS, Atlanta, Ga.: I have enjoyed Dr. Richardson's paper and think it very timely. At about the time Sharpe was carrying out his work on intracranial hemorrhage I was making similar studies on the new-born negro. Routine lumbar punctures have been performed on approximately five hundred of these babies, fourteen and one-tenth percent of whom showed evidence of intracranial hemorrhage. Of the sixty hemorrhage cases which I have attempted to follow, twelve are dead—ten due to the hemorrhage, two because of some intercurrent infection; forty-two are known to be alive and only two of these show any evidence of intracranial hemorrhage, the other forty are apparently normal.

As to the coagulation time, I think absolute dependence can not always be placed in this phenomenon. I have seen two or three infants that showed definite hemorr-

hage from the intestines and skin with a coagulation time below eight minutes. Of the sixty hemorrhage cases only two could be classified as hemorrhagic disease of the new-born.

The subsequent development of the forty-two living infants will be watched with keenest interest and may throw considerable light on the true significance of hemorrhage into the spinal fluid of the new-born.

I wish to thank Dr. Richardson for his paper.

DR. E. N. GLEATON, Savannah, Ga.: I have greatly enjoyed Dr. Richardson's discussion of intracranial injuries. It was Little, of London, who, in 1873, gave us the first information concerning these injuries, he being a neurologist. In 1903, or 1902, Finkelstein gave us some information, he being a pediatrician, and in 1922 Ehrenfest, of St. Louis, gave us the best information, in my opinion. Eustace, of Boston, has attempted to show that most of these troubles are caused by asphyxiation, but Ehrenfest says they are the cause, rather than the result, of asphyxiation.

In regard to the treatment of the cases, especially those with hemorrhage, we should give whole blood. We can give from 20 to 60 c.c. of the mother's or father's blood subcutaneously, and the earlier we do this the better. As Dr. Richardson said, we do not have to type the blood at all.

Early diagnosis is the main thing in this condition. The transfusion may be repeated if necessary. The blood clotting and bleeding time is necessary in all these cases and we should repeat the treatment in twenty-four hours if we do not get proper results.

DR. C. H. RICHARDSON, Jr., Macon, Ga., (closing): I wish to emphasize one or two points. First, regarding asphyxiation. The presence of this in the new-born should always be a danger signal. Too often a baby that we think is simply asphyxiated is having a hemorrhage, and if we make too violent efforts at resuscitation more damage is done. I did not mean to indict the obstetrician particularly, but the fact that these things do occur in many labors makes it seem that a timely warning to the obstetrician now and then is valuable. We must look for the mild cases, the cases in which the child at birth is apparently normal. The severe ones seldom live but in the mild cases the child is apparently all right for two or three days. I recall a case seen recently, a forceps delivery, that showed just a slight degree of paresis. This cleared up and only on the third day did the child cease to nurse. The sucking reflex was

abolished, and soon it was evident that something was wrong. Lumbar puncture revealed bloody spinal fluid. The baby was unable to nurse or swallow and had to be fed for several days through a nasal tube. Injections of whole blood from the father were given. There is no hemolysis up to a year and no danger in taking blood from either the father or mother up to that time. We injected the whole blood and made repeated lumbar punctures and the child has made what appears to be a perfect recovery. It is now three months old and I saw it recently. It appears to be normal in every way.

## PROGRESS NOTES ON CASE REPORTED

BY DRS. H. W. BIRDSONG, M. A.

HUBERT AND G. O. WELCHEL,  
ATHENS.

The following notes were sent in by Dr. Birdsong in regard to the case reported in the article, "Splenic Anemia," which appeared on page 453 of the November, 1925, issue of the Journal:

"The patient was given a third X-ray treatment which entirely checked the uterine bleeding. She is now able to be up but is still very anemic and with a color index of less than 1. Patient is still under observation and a final report will be given at a later date."

## ANURIA RELIEVED BY URETERAL CATHETERIZATION IN A CASE OF RENAL HYPOPLASIA

Julia C. Strawn, Howard Chislett and Daniel N. Eisendrath, Chicago (Journal A. M. A., May 2, 1925), relate the case of a patient who had a right kidney which failed to develop; it was in a condition of hypoplasia. Following exposure to cold, by falling into the water and lying on the sand until his clothes were dry, there was an acute congestion of the left kidney, followed by colicky pains—a not infrequent accompaniment of such acute congestion. The burden of urinary excretion was thrown on the right (embryonic kidney, which was unable to carry the burden, with the resultant almost complete anuria and symptoms of renal insufficiency. Ureteral catheterization gave relief.



## CHOICE OF ANESTHESIA IN SURGICAL OPERATIONS OF THE RECTUM

Marion C. Pruitt, M.D.

Atlanta, Georgia

The question of anesthesia in relation to operations on the rectum and anus is very important to the success of the doctor and the life and comfort of the patient. As every one knows, there are many methods of anesthesia used in rectal surgery. There is no one best method for all cases. The selection of an anesthetic depends on:

- 1st. The general condition of the patient.
- 2nd. The local condition to be treated.
- 3rd. The skill of the operator in the application of the different methods of anesthesia.

The ideal anesthetic is one that will not cause any disturbance in the general condition of the patient at the time of the operation, apart from unconsciousness, will not produce added risk to the operation, and will completely protect the patient against post-operative shock. With our present knowledge it is impossible to obtain these requirements except in a few minor cases. In the last few years much progress has been made towards producing an ideal anesthetic thru the more extensive use of the different methods of local and regional anesthesia, or in combination with general anesthesia.

The methods to be considered are:

#### 1. General anesthesia.

A complete physical examination of the patient is essential. No patient with a diseased condition of the heart, lungs, or kidneys should be given a general anesthetic for rectal operations.

Chloroform is, as a rule, not safe. Interference with the sphincter muscle stimulates the respiratory center, and causes very deep breathing, and may result in an over dose of chloroform. If chloroform is to be used, the patient should be thoroughly anesthetized; the cone should then be removed from the face while the sphincter is being dilated.

Ether is less dangerous, and just as efficient.

Gas and oxygen are a much more agreeable anesthetic than chloroform or ether, but frequently, in low grade chronic inflammatory conditions with marked hypertrophy of the sphincter ani, it does not give suf-

ficiently deep anesthesia, and it is necessary to give small amount of ether until the sphincter is dilated.

Twilight Sleep: This method was introduced as a substitute for chloroform and ether in childbirth. It is now frequently used to aid in surgical anesthesia. The chief objection to its use is that once the injection is given the anesthetist has, to a large extent, lost control of the anesthetic. Scopolamine and morphine or omnopon are used hypodermically. As the dose for each patient varies, it is necessary for the anesthetist to see the patient every few minutes during the induction, so as to give further doses. After the injection, the patient should remain quiet. This is not a safe or satisfactory anesthetic when given alone as a complete anesthesia, but has many decided advantages in certain cases when combined with local or regional anesthesia, and not pushed to complete anesthesia.

Synergism of magnesium sulphate and morphine: Recently considerable clinical literature has appeared on the synergism of magnesium sulphate and morphine, or a combination of morphine sulphate in 25% solution of magnesium sulphate. Various claims have been made; some stating that the addition of 2 to 5 c.c. of a 25% solution of magnesium sulphate to the usual hypodermic of morphine increases the value of the hypodermic from 50 to 100%. Most of the observations reported were on the increased ability to lessen the pains of childbirth. My observation of magnesium sulphate and morphine combination leads me to believe that it does not have any increased value over the morphine given alone.

#### 2. Spinal anesthesia:—novoeain, tropocain, 5% solution 15 to 20m.

For many operations upon the rectum and anus this is a very satisfactory method. The after effect, chiefly giddiness, headache, vomiting, incontinence of the sphincter, retention of urine and syncope, which occur occasionally, are very disturbing.

Spinal anesthesia usually gives perfect anesthesia with complete muscular relaxa-



tion. But the failures are so frequent, 5-10%, and the complications are so disturbing, with a mortality of 3 to 2000, that its use is not advisable except in a few cases. Its strongest advocates do not usually last very long.

### 3. Blocking of the sacral nerves.

The sacral nerves can be injected one by one, by passing the needle through the posterior sacral foramina. The procedure constitutes trans-sacral route of Davis. They also can be reached at their exit from the anterior aspect of the sacrum. This procedure is termed the para-sacral conduction anesthesia of Braun or the pre-sacral block.

The sacral nerves can be reached in a third way by passing the needle through the sacral hiatus, and depositing the solution within the sacral canal. This is known as the Caudal Block.

The result obtained following each procedure is similar. The technique is difficult, and the anesthesia is no better, and probably not as constant as some of the less technical methods, and is only used by a few who are skilled in the technique of this procedure.

### 4. Local anesthesia.

Infiltration of the local tissue around the rectum and anus is probably the most simple of all procedures, and generally the results are good, but, like spinal anesthesia, field block or nerve block, occasionally it fails to complete muscular relaxation and loss of sensation. A small acute, thrombotic pile may be frozen with ethyl chloride.

In cases with relaxed sphincter, local anesthesia with nerve block of pubic nerve gives most satisfactory results. The combination of twilight sleep and local infiltration makes a very desirable anesthetic for the surgeon, but the hyoscine may be very dangerous to the patient, and should be given with caution.

The combination of gas-oxygen and local infiltration gives complete relaxation, loss of consciousness, tends to prevent post-operative shock, with very little disturbance to the general condition of the patient, and very slight post-operative symptoms. The results from the combination are safe, uniform, and constant.

Again, let me say: There is no one best method of anesthesia for all cases. To ob-

tain results in rectal conditions we must consider the general condition of the patient, the local condition to be treated, and the skill of the operator in the method to be used. This consideration is due each patient.

The following case reports illustrate the choice of anesthesia used in some of my recent work:

#### Case 1.

Mr. B. G. R. Male. Age 55. Referred to me by Dr. M., on March 19, 1924, with a history of bleeding, protruding piles, which started about nine years ago. He has had muscular rheumatism at times since childhood. Typhoid fever age 17. About four years ago he had an abscess just outside of rectum, which was followed by discharging sinus, just to the right of median line about one inch behind rectum.

Physical examination revealed the following: Chest negative. Mitral systolic murmur apex transmitted to axilla. Systolic blood pressure 170; diastolic 110. Protruding, internal hemorrhoids, four tumors, which protruded after each defecation, and could be returned by the patient. The discharging sinus about one inch posterior to rectum on right side of median line. A probe was easily passed through sinus into rectum. The following anesthesia was used in this case:—combination of twilight sleep, or morphine  $\frac{1}{4}$ , hyoscine  $\frac{1}{200}$ , one hour before time of operation; one per cent of novocain infiltration around rectum and region of fistula tract and blocking of the pubic nerves. Excision of fistula tract and hemorrhoidectomy was done with very little discomfort to patient. This type of anesthesia was selected on account of heart condition.

#### Case 2.

Mr. R. L. R. Male. Age 38. Seen on September 18, 1924. Had history of poor health since he was gassed in 1918. For the last six days he had had acute pain between scrotum and rectum. For the last three days he had noticed a very painful mass, which had gradually increased in size. Diagnosis: Ischio rectal abscess. A two per cent novocain solution was used to infiltrate the tissue over the mass. Incision was made in line of infiltration, and much pus escaped. Drainage was placed in cavity. Two per cent solution of novocain was used in this case,

because in an inflamed condition it is difficult to infiltrate the tissue. In using a stronger solution, it is necessary to use but very little solution. This practically eliminates the discomfort which is caused by the inflammatory condition in this case.

### Case 3.

Mr. L. S. Male. Age 59. Referred by Dr. C. Seen on August 16, 1924. Complaining of general breakdown, indigestion, mucus colitis, and protruding, bleeding piles, which would protrude during each defecation, and could only be returned after much effort on the part of the patient. He had a history of suffering from protruding piles for about 39 years. For the last three or four weeks he had been suffering from intense pain, burning and tenesmus in the rectum, which was exaggerated after each movement. Physical examination showed a very anemic, wasted, flabby muscular condition, mucus colitis, protruding, internal hemorrhoids and fissure in ano. One per cent solution of novocain was used to infiltrate the area of fissure. An incision was made in the base of the fissure through to the muscle, followed by immediate relief. Later this patient's piles were treated by injection. His rectal condition entirely cleared up. Local anesthesia was used in this case on account of the patient's age, and his general systemic condition.

### Case 4.

Mrs. J. L. T. Female. Age 47. Referred by Dr. D., on April 24, 1924, with a history of habitual constipation since childhood, irritation of the rectum and bleeding piles for the last 22 years. She had had all kinds of local treatment with ointments, pressure bougies, and high frequency. Examination revealed several small internal piles, which protruded very little, and returned spontaneously after each defecation; a very marked hypertrophy of the sphincter ani, so much so that it was difficult to pass the forefinger; the mucus membrane of the rectum and anal rectum was very much indurated and thickened, due to a low grade inflammatory condition. Because of the marked hypertrophy of the sphincter, it was decided best to use a general anesthetic. The anesthesia was started with gas oxygen, and then switched to ether just long enough to get a

relaxed condition until the sphincter was dilated. The operation was then finished under gas oxygen. It was necessary, in this case, to give this patient a second general anesthetic to dilate the sphincter, and stretch the scar tissue to prevent stricture about two months after the first operation.

### Case 5.

Mrs. A. E. O. Female. Age 42. Widow. Complaining of almost complete obstruction of the lower bowel, with mucus and blood in stools.

Past History: About 17 years ago she produced abortion by passing a lead pencil into the cervix. This did not act as quickly as she thought it should, so she resorted to a hatpin. This was followed by an abortion and localized pelvic peritonitis with perirectal abscesses. The abscesses were opened externally. In the last eight or ten years she has had eight or ten abdominal and pelvic operations. About eight years ago she had a total hysterectomy for a clinical diagnosis of tuberculosis of the uterus. No microscopical examination was made. A vesicovaginal fistula followed this operation. Three attempts were made to repair the fistula before it held. For the past five years a post-operative stricture has gradually formed in the lower part of the rectum about two inches from the anus. This has been mechanically dilated several times under gas-oxygen anesthesia, only to return again.

The rectal examination revealed a hard fibrous stricture of the rectum, about one and one-half inches from anal margin, which would barely admit No. 10 catheter. Under spinal anesthetic (novocain 20 drops of 5% solution) the stricture was mechanically dilated with no discomfort to patient, other than a numbness of the lower extremities and a fainty feeling which disappeared in a few minutes, and with perfect relaxation from the surgical standpoint.

The selection of spinal anesthesia in this case was (1) because of the general condition of the patient, (2) because of the patient's refusing to take general anesthesia, stating that she had just as soon die as to take another ether anesthesia, (3) because we felt spinal anesthesia would give less discomfort and better relaxation than any other method except general.



# THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Profession of Georgia.

65 Forrest Ave., Atlanta, Ga.

DECEMBER, 1925

ALLEN H. BUNCE, M. D., Editor

Publication Committee

CHAS. USHER, M. D.

S. J. LEWIS, M. D.

T. C. THOMPSON, M. D.

Articles are accepted for publication on condition that they are contributed solely to this Journal.

Manuscripts should be typewritten, double-spaced, and the original (not the carbon copy) submitted. Used manuscript is not returned unless requested.

Communications and items of general interest to the profession are invited from all parts of the State. We especially invite county society secretaries to send us information of happenings in the county that would be of interest to the members throughout the State.

Reprints should be ordered within 30 days after the appearance of an article, since all type will be destroyed at the end of that time.

## Editorial Department

### THE SEASON'S GREETINGS

To each and every member of the Association we extend sincere greetings and best wishes for a Merry Christmas and a Happy New Year. May God's choicest blessings be showered upon you and yours during this Yuletide Season.

### GEORGIA SECURES NEXT MEETING OF THE SOUTHERN MEDICAL ASSOCIATION

At the nineteenth annual meeting of the Southern Medical Association held in Dallas, Texas, November 9th to 12th, Atlanta was selected as the next place of meeting. This means much to Georgia and the entire Southeast and we welcome the opportunity of entertaining such a distinguished body of medical men. We should have the largest gathering of physicians ever assembled in Georgia since it will give us an opportunity to see, hear and learn from the leaders in medical knowledge of the present generation.

There were more than two thousand phy-

sicians registered at the Dallas meeting and the total registration exceeded two thousand eight hundred. Dr. Stewart R. Roberts, of Georgia, President, presided and his address before the first general session on "William C. Gorgas of Alabama" was a classic. It was generally conceded to be the best oration ever delivered before the Association. (It's great to be a Georgian). At the same session Dr. William L. Dunn, of Asheville, N. C., delivered the oration on medicine using as his subject, "The Passing of Tuberculosis," and Dr. Evarts A. Graham, of St. Louis, Mo., delivered the oration on surgery, entitled "What in Surgery?" At the second general session Dr. Irvin Abell, of Louisville, Ky., addressed the Association on "Surgery in the South." The meeting was especially honored by the presence of Dr. W. D. Haggard, of Nashville, Tenn., President of the American Medical Association, who spoke on "What Price Health?" Dr. Charles H. Mayo gave an entertaining and masterful address on "Avian Tuberculosis of the Spleen and Liver."

In addition to these general sessions there were seventeen scientific sections, all of which were well attended. The papers and discussions furnished a condensed post-graduate course in medicine and surgery. How much more helpful it is to see a man, hear him talk, ask and answer questions than it is merely to read his paper after it has been published can be attested by every one in attendance. Actual attendance helps one to evaluate properly what is presented. Fifty members of the Medical Association of Georgia were in attendance which demonstrates the interest of our profession in scientific medicine.

Dr. C. C. Bass, of New Orleans, Dean of Tulane University School of Medicine, and one of the best known physicians in America, was selected as the next President.

It would be amiss not to mention the Woman's Auxiliary. In fact the women were so busy with their meetings and being entertained that we mere doctors ceased to be even the nominal heads of our households. The men were given much food for thought and banquets and dinners, but the ladies were royally and lavishly entertained from



"early morn to early morn." Mrs. D. J. Williams, of Gulfport, Miss., was selected as the next President of the Woman's Auxiliary of the Southern Medical Association.

Let's all get together and give this Southern institution the largest and best meeting it has ever had in Atlanta next November.

### CONFERENCE OF SECRETARIES AT A. M. A. HEADQUARTERS

On November 20th and 21st the annual conference of secretaries of constituent state medical associations and editors of the state medical journals was held at the headquarters of the American Medical Association in Chicago. At the same time the conference on periodic examinations of apparently healthy persons authorized by the House of Delegates of the A. M. A. at the Atlantic City meeting was brought together. The Board of Trustees was present 100% strong. Both the President, Dr. W. D. Haggard, of Nashville, Tenn., and the President-Elect, Dr. Wendall C. Phillips, of New York, were in attendance. Many of the leaders in medical organization, medical teaching and public health work participated with papers, lectures, demonstrations and discussions. A complete report of the proceedings will appear in the December issue of the A. M. A. Bulletin.

### NEWS ITEMS

Drs. B. H. Wagnon, E. C. Davis, L. M. Gaines, James N. Brawner, M. F. Benson, W. A. Selman, B. H. Clifton, E. H. Greene, all from Atlanta, and B. T. Wise, Plains, and J. C. Patterson, Cuthbert, attended the annual meeting of the American College of Surgeons which was held in Philadelphia during November. They also attended clinics held at the Mayo Clinic, Rochester, Minn., and the Cleveland and Lakeside Clinics, Cleveland, Ohio.

We were mighty glad to receive a letter from Dr. W. C. Williams, Jr., formerly of Cochran, but now Delray, Florida, and to learn that he is doing so well in his new location. Before leaving the State Dr. Williams was Vice-President of the State Board of Medical Examiners and a member of the Ocmulgee Medical Society.

Dr. Thos. R. Gaines, of Hartwell, left the first part of November for New Orleans, Louisiana, where he is taking a six-months post-graduate course on the eye, ear, nose and throat at the Tulane Graduate School of Medicine. Dr. Gaines

held the office of Secretary-Treasurer of the Hart County Medical Society up until this year when he was elected President.

Dr. Arthur W. Wood has opened offices at 262 W. Flagler Street, Miami. Before removing Dr. Wood was one of the most prominent physicians in Albany and was Secretary-Treasurer of the Second District Medical Society. He is a member of the Dougherty County Society and one of its Ex-Presidents.

Dr. Stewart R. Roberts, of Atlanta, and 1924-1925 President of the Southern Medical Association has been appointed to the Directorate of the Gorgas Memorial Institute, of which President Coolidge is titular head. This Institution is devoted to the purpose of reducing preventable diseases.

An announcement was received of the association of Dr. Arthur G. Fort with Dr. Rufus J. Pearson. Their offices are located at 544 W. Flagler St., Miami, Fla. Practice limited to Ophthalmology and Oto-Laryngology. Dr. Fort formerly had offices at 436 Peachtree St., Atlanta.

At a recent meeting of the State Board of Medical Examiners, Dr. J. W. Palmer, Ailey, was re-elected President, Dr. C. M. Paine, Atlanta, was elected Vice-President and Dr. C. T. Nolan, Marietta, was re-elected Secretary-Treasurer. Others present were Drs. M. F. Carson, Griffin; N. Peters, Tifton; H. F. McDuffie, Atlanta; O. B. Walker, Bowman; J. O. Elrod, Forsyth, and John M. Anderson, Barnesville.

Dr. W. W. Young announces that he is prepared to provide care for a small number of nervous cases requiring prolonged observation and treatment with moderate maintenance. This includes mild mental disorders, borderline nervous disorders of any type and selected cases of addiction. Dr. Young is a member of the Fulton County Medical Society and has offices at 41 Forrest Avenue, Atlanta.

Dr. B. H. Minchew, of Waycross, has been made a Fellow in the American College of Surgeons. The degree was conferred upon him during the recent meeting in Philadelphia. Dr. Chas. H. Mayo, of Rochester, Minn., is President of the College.

Dr. Harry B. Nunnally having recently been associated with Dr. G. D. Ayer in the Hurt Building, Atlanta, has returned to Monroe, his native city, to resume his practice. The members of the Fulton County Medical Society regret that his removal takes him into another county.

Dr. Arch Elkin gave an interesting talk to the Atlanta Lodge No. 78, B. O. P. Elks, November 5, 1925, on the Good Samaritan Clinic, of which he is Medical Director. Dr. Elkin's lecture was beneficial and enjoyed by all present.

Dr. T. C. Thompson, Vidalia, was honored by being elected a Fellow of the American College of Surgeons and received his degree while attending the annual meeting held during November in Philadelphia. Dr. Thompson is Councilor from the Twelfth District and a member of the Toombs County Medical Society.

Dr. George L. Cook, formerly of Atlanta, has announced the formation of a partnership with Dr. Douglas D. Martin, with offices in the Citizens Bank Building, Tampa, Florida. Practice limited to Diseases of Children.

We have been notified by Dr. J. H. Riley, of Haddock, and President of the Jones County Medical Society, of the removal of Dr. J. D. Zachary from Bradley to Gray, which is also in Jones County. The friends of Dr. Zachary wish him continued success in his new location.

The new John D. Archbold Memorial Hospital at Thomasville has been given a Class A rating by the American College of Surgeons. This announcement was received with a great deal of interest as Thomasville is proud of her Hospital and justly feels that it should be ranked with the best.

Drs. E. C. Thrash, Councilor from the Fifth District and an Ex-President of the Association, and C. E. Downman have returned to Atlanta after a visit to the Mayo Clinic, Rochester, Minn.

Dr. N. J. Guthrie has opened an emergency hospital in Norcross. He has leased the Buchanan building and divided it into private rooms, wards and a laboratory. Dr. Guthrie is Secretary-Treasurer and a past President of the Gwinnett County Medical Society.

Dr. T. C. Thompson, Vidalia, and Dr. J. W. Palmer, Ailey, were the principal speakers on the annual public health program of the Vidalia Woman's Club at their meeting held in November.

Dr. George Y. Massenberg, Macon, was among the Georgia doctors attending the meeting of the American College of Surgeons at Philadelphia. Dr. Massenberg received his Fellowship degree last year.

Dr. L. W. Hodges has removed from Winder to Gainesville, where he has taken over the practice of Dr. J. R. Simpson. Dr. Hodges retained the offices of Dr. Simpson in the Jackson Building. He was one of Winder's most successful physicians and was Vice-President of the Barrow County Medical Society.

We were very pleased to learn that Dr. Joe E. Lane has returned to LaGrange after having removed to Houston, Texas, last year. The doctors of Troup County are welcoming him back in their Society again.

The following members of the Hart County Medical Society have been appointed by the Red

Cross headquarters at Washington, D. C., to cooperate with this organization in the examination of the school children in Hart County: Drs. B. C. Teasley, Chairman; W. E. McCurry, Vice-Chairman; W. I. Hailey, J. C. Jenkins, A. O. Meredith, Geo. S. Clark, Thos. R. Gaines, A. P. Hanie, all of Hartwell; Joe I. Jenkins, Bowman, and G. T. Harper, Dewey Rose.

After twenty-five years of service the Park View Sanitarium at Savannah is to be closed. In 1900 this hospital was organized by Drs. Ralston Lattimore, John W. Daniel, St. Joseph B. Graham, A. B. Simmons and Geo. R. White. Dr. Lattimore stated that its physical and financial condition was better now than at any time in its previous history, but that the directors had decided it advisable to concentrate the medical interest and energy rather than distribute it over many hospitals.

The Wesley Memorial Hospital at Emory University, Georgia, has admitted more than 600 patients to the Out-Patient Clinic which was opened during July. This clinic is for the benefit of the poor people of Georgia who live outside of the Hospital and come to the clinic during visiting hours. There is a registration fee of fifty cents for the first visit and ten cents for each additional visit. Laboratory tests, surgical dressings, x-ray examinations and anesthetics are furnished at cost. This is the first clinic of its kind to be opened in Georgia, and it has proven to be a great benefactor to the poor.

Atlanta and Fulton County will be hosts to those attending the meeting of the Southern Medical Association next year as Atlanta was selected as the 1926 meeting place. There will be about five thousand doctors present.

Our membership has now reached 1754 for 1925, which is the largest paid-up membership in the history of the Association. Let's strive for 1800 for 1926!

### AMERICAN BOARD OF OTOLARYNG- OLOGY

An examination was held by the American Board of Otolaryngology on October 19, 1925, at the Cook County Hospital, Chicago, with the following result:

Passed .....	120
Failed .....	23

---

Total examined .....	143
----------------------	-----

The next examination will be held in Dallas, Texas, on April 19, 1926. Applications may be secured from the Secretary, Dr. H. W. Loeb, 1402 South Grand Boulevard, St. Louis, Missouri.

**THE FLORIDA SANITARIUM**

To the Editor:

In your letter of November 3, you expressed a willingness to run a news item concerning our institution in your next issue.

We feel, Doctor, that we have one of the finest institutions in the Southeast, and we believe the only Sanitarium conducted along the same lines as the Battle Creek Sanitarium. We are one of a chain of institutions which circle the globe and all of these had their inception at Battle Creek. Our nearest Sanitarium to Florida is the Washington Sanitarium at Washington, D. C. Then, we have one in Melrose, Massachusetts; Hindsdale, Illinois; Boulder, Colorado, and we have five in California and many others scattered over this country as well as other countries.

The Florida Sanitarium was established in 1908 and since that time has experienced a steady constant growth. The inclosed folder will give you an idea as to the sort of treatments and service we give. Last winter we feel sure that we turned away at least as many patients as we received due to a lack of space. We have tried to forestall a repetition of this experience by erecting an addition.

This addition is nearing completion and will give us twenty-two more patients' rooms as well as a splendid Physiotherapy Department, 60 ft. long by 15 ft. wide. We will also have a splendid new Laboratory, Pharmacy, Eye, Ear, Nose and Throat Department, and two suites of doctors' offices, as well as other needed office space.

At present, we have a class of 60 nurses in training, as well as 85 other employees.

Our work is carried by the Seventh-day Adventist Denomination and is operated on a non-profit sharing business, extending charity where there is a real need. Dr. L. L. Andrews is our Medical Superintendent, assisted by Drs. A. J. Balkins, N. E. Vredenburg and C. P. Farnsworth.

We hope that this little information will furnish you with material to give us a write-up which will better acquaint the people in this section with our institution. Be sure and impress them with the fact that it is not necessary for them to travel all the way

to Battle Creek, Michigan, for we have a Battle Creek right here in Orlando. In fact, we have scores of patients who come from the Battle Creek institution to our Sanitarium each winter.

Thanking you for your cooperation, we are,

Very truly yours,  
THE FLORIDA SANITARIUM,  
E. L. Place, Manager.

**GLAND THERAPY**

Some medicaments can be assayed, and thus standardized, by chemical means—such as belladonna, cinchona, hydrastis, nux vomica, etc.; others by physiological methods, as ergot, digitalis, aconite, convallaria, etc.; but now that gland products are coming into such extensive use, how is the physician to be assured of their activity?

Some of them, it is true, are tested by chemical or physiological means, for example desiccated thyroid, adrenalin, and pituitrin, but for the majority there is no assurance beyond the care of the manufacturer in handling the fresh glands and applying suitable methods of desiccation or extraction. The hormones must be preserved; otherwise the gland product is simply so much protein. Here if anywhere the reputation of the manufacturer is a matter of prime importance. Physicians who are particularly interested in gland therapy should read what Parke, Davis & Co. have to say, in their advertisement in this issue about their methods of manufacture.

**FREDERICK K. STEARNS MEMORIAL FELLOWSHIP.**

Frederick Stearns & Company have founded at the University of Michigan, the Frederick Kimball Stearns Memorial Fellowship in Medicine, in honor of the late Frederick Kimball Stearns.

Mr. Stearns was a life-long patron of the Arts and Sciences, and had shown a special interest in the progress of the University of Michigan. The Stearns' Botanical Gardens, the Stearns' Fellowship in Pharmacy and the Stearns' Collection of Musical Instruments, the most complete collection of its kind in the world, were evidences of his interest and generosity.

While the medical fellowship is to be used at the direction of the University medical authorities, the work during the coming year will be devoted to researches on Insulin and Insulin therapy. The study of this problem has been of the greatest interest also in the Scientific Laboratories of Frederick Stearns & Company in the course of the development of their product, "Insulin-Stearns," which has been so extensively used in the treatment of diabetes.



## District and County Societies

### District Editors

- |                                 |                                |
|---------------------------------|--------------------------------|
| 1. McGee, H. H., Savannah.      | 7. McCord, M. M., Rome.        |
| 2. Watt, C. H., Thomasville.    | 8. Carter, D. M., Madison.     |
| 3. Greer, Chas. A., Oglethorpe. | 9. Bennett, J. C., Jefferson.  |
| 4. Williams, C. O., West Point. | 10. Lee, F., Lansing, Augusta. |
| 5. Pitts, Jno. B., Atlanta.     | 11. Penland, J. E., Waycross.  |
| 6. Thompson, O. R., Mable.      | 12. Cheek, O. H., Dublin.      |

### HONOR ROLL

The following is a list of 100 per cent counties for 1925. The date on which each became a 100 per cent society appears after the name of the society, together with the name of the Secretary:

1. Randolph County, Dr. G. Y. Moore, Cuthbert, December 9, 1924.
2. Dougherty County, Dr. J. A. Redfearn, Albany, December 10, 1924.
3. Pike County, Dr. M. M. Head, Zebulon, December 12, 1924.
4. Hart County, Dr. W. E. McCurry, Hartwell, January 3, 1925.
5. Warren County, Dr. A. W. Davis, Warrenton, January 14, 1925.
6. Monroe County, Dr. W. J. Smith, Juliette, January 14, 1925.
7. Lamar County, Dr. John M. Anderson, Barnesville, March 6, 1925.
8. Crisp County, Dr. Byron Daniel, Cordele, March 11, 1925.
9. Upson County, Dr. B. C. Adams, Thomaston, March 30, 1925.
10. Emanuel County, Dr. S. S. Youmans, Oak Park, May 5, 1925.
11. Stephens County, Dr. C. L. Ayers, Toccoa, May 11, 1925.
12. Turner County, Dr. J. H. Baxter, Ashburn, May 12, 1925.
13. Evans County, Dr. D. S. Clanton, Hagan, May 14, 1925.

### Second District Medical Society

The meeting was called to order by Dr. C. K. Sharp, President, at 9:30 A. M., September 11, 1925, with Invocation by Rev. A. H. Robinson, of Cairo.

The Welcome Address was given in a few well chosen words by Mr. J. A. Pope, of Cairo, in which he praised the physician and

surgeon for the value of these men to the community and opened the doors of Cairo for a hearty welcome.

Dr. H. M. Moore was asked by the president to respond to Mr. Pope's address, which he did, expressing the appreciation of the Society for the invitation on the part of Cairo and the Grady County Medical Society.

First on the program was a discussion of a case of "Thrombosis of the Cavernous Sinus," which condition usually follows infection of the mastoid, erysipelas, infected tonsils, or other foci. His report was most interesting, in that it dealt with those remote conditions that require painstaking study and observation for diagnosis.

Dr. I. W. Irvin, Albany, in discussing the case, stated that it is most interesting because so rare. He advises that in cases of obscure, yet local infection, mastoid operation be done. He mentioned endocarditis, uremic coma as likely responsible for some of the symptoms in these cases. He gave brief report of two cases of sinus thrombosis following mastoid infection.

Dr. Moore, closing, replied to the inquiry of Dr. J. L. Summerlin, that there was no primary sinus or antrum infection; only a continuation of the infection from the cavernous sinus to the circular sinus.

Dr. Frank K. Boland, President of the Medical Association of Georgia, mentioned by introduction, that, though timeworn, his subject, "Diagnosis and Treatment of the Surgical Abdomen," was practical. He wished, however, to modify the wording to that of "Abdominal Pain."

"Pain is the most valuable asset to diagnosis in abdominal conditions. The acute abdomen is pain." He urged more careful and complete diagnosis by the family physician, and on the part of the surgeon, the lesser of two evils, particularly in urgent

cases, is exploratory operation against undue delay. He urged every means of diagnosis before hasty operations. He mentioned many obscure or remote non-surgical conditions to be differentiated.

Intestinal colic and ptomain poisoning are easily differentiated from surgical conditions. Pressure on the abdomen in simple colic gives relief, but intensifies the pain in appendicitis or other infections. If after evacuation the pain remains, look for appendicitis. Differentiation must be made to posterior root disease, as tabes, and to caries. Regional pain, hypogastric for large intestines, umbilical for small intestines, epigastric for stomach. In appendicitis if the obstructive case is first in the appendix, then in the intestines, as compared to the usual type of appendicitis, "Pain must be the first symptom in appendicitis." Other differential conditions are perforated gastric ulcer, movable kidney, twisted ovary, stone in kidney or ureter, thrombosis, etc.

The pain and rigidity of perforation are more intense than in non-perforating inflammation, though the pain of acute pancreatitis is said to be the most intense of all abdominal pain, general at first, later localized.

He called attention to abdominal injury without external wounds, as rupture of the liver, spleen, intestines, etc., and places the responsibility for the outcome on the man who first sees the case.

Dr. A. D. Little, Thomasville, reported a case in discussing Dr. Boland's paper illustrating the difficulty of diagnosis.

Dr. Sharp asked when, if ever, should purgatives be given in appendicitis.

Dr. Boland, closing, stated that never should purgatives or high enema be given in appendicitis; especially he urges that the laity be educated to have the physician see the patient and determine what should be done before purging the patient. He urges careful observation and the fitting of symptoms to the pathology found.

Dr. Stewart R. Roberts, on "the Relation of the Size of the Heart to Heart Disease, with reference to the use of Digitalis" in his most interesting way presented several cases, through courtesy of Dr. Walker, showing abdominal angina with arteriosclerosis and

cardiac decompensation; also a case of right heart failure in cardiac asthmatic, and a case of bronchial asthma (emphasematous). These cases may also develop cardiac valvular insufficiency.

Dr. Roberts, in his discussion of blood pressure, stated that low blood pressure, unassociated with any cardiac pathology, is conducive to longevity. The blood pressure is influenced by the altitude in which we are living, the nearer the sea level, the lower the pressure. His discussion was most interesting.

With reference to digitalis, which slows the pulse, increases kidney function, and strengthens the cardiac muscle, it may produce nausea and vomiting, diarrhea, disturb vision and mentality. Its chief function is to slow the pulse and strengthen muscle. Give digitalis until results are obtained, but the patient's condition, etc., must determine the administration. Usually body weight regulates the dose, though the severity of the case should be considered. He prefers the powdered leaves, stating that twelve grains of the leaves digitalize a man of one hundred fifty pounds and that one grain daily thereafter, will maintain digitalization. He advises comfort for the chronic heart cases, sleep being essential to the rest of the tired heart, and opiates if needed.

Dr. J. W. Daniel, past President of the Medical Association of Georgia, who has several times delighted us with his instructive discussions, had as his subject matters of Public Health. He said that Georgia's greatest evils are ignorance and dirty politics. He mentioned the various health conditions calculated to produce defective children and disable adults in Georgia, as malaria, typhoid and hookworm, and urged the enactment of the Ellis Health Law in Grady County. In the discussion he gave figures and illustrations throwing much light on this subject and the great indifference of the people of the state to their existence, and their greater interest in material things. His message was followed by unanimous vote of appreciation of the message and his interest in better health conditions in Georgia, with a pledge of support in putting over the suggestions made, and the Ellis Law into effect in Grady County.

Dr. L. A. Baker being unable to attend the meeting, the time was allotted to Dr. I. M. Lucas of Albany, with discussion by Dr. J. M. Redfearn. Dr. Lucas gave a brief discussion of rickets, in which he emphasized the dietary and metabolic disturbances, the fat-soluble vitamin "A," calcium and phosphorus particularly in bone being deficient. He urged cod-liver oil extract and parathyroid extract in the treatment in addition to a well balanced diet.

Dr. Redfearn, discussing the subject urged more careful observation as the disease is more prevalent than we have believed. He urged proper food and sunlight, or therapeutic light.

Dr. Moore, of Tallahassee, Fla., cautioned us to greater care in preventing the cases from developing to active symptoms, by plenty of sunlight, ultraviolet rays, good food of sufficient calcium, as milk, vegetable extract to be given early to the child, instead of proprietary foods, which are deficient in vitamins and calcium.

Dr. J. A. Summerlin, on "Foci of Infection," spoke of colds, and the remote conditions that may result, both immediate and latent, and the local conditions that aggravate or make possible the infection. He stated that colds are too greatly neglected by the laity.

The absence of Dr. C. K. Wall on account of the death of his father was greatly regretted and his paper was not called for. Also, on account of Dr. Wall's absence Dr. J. C. Keaton asked to withhold the reading of his paper on "Nonsurgical Vesicle neck Obstruction and Treatment."

On account of the resignation of Dr. A. W. Wood, as Secretary of the Society, a committee composed of Drs. Keaton, Covington and Moore, was instructed to nominate his successor to fill the unexpired term. The Committee named Tifton as the next meeting place, and recommended that the months for the meetings be changed to April and October, and that Dr. Chas. H. Watt, of Thomasville, be elected as Secretary. The report was favorably accepted.

A. W. WOOD,  
Retiring Secretary.

Since this meeting Dr. Wood has moved to Miami, Florida. We shall miss him as District

Editor from the Second District as he was always on the job and cooperated with us to the fullest extent.

### TENTH DISTRICT MEDICAL SOCIETY

The Fall meeting of the Tenth District Medical Society was held in the John T. Brantley Building of the Georgia State Sanatorium at Milledgeville, Tuesday, October 27, 1925.

The meeting was called to order at ten-thirty A. M., by the President, Dr. R. C. Swint, of Milledgeville, who at this time took occasion to extend a warm welcome to all in attendance.

The minutes were next read and approved and the following papers were read and discussed:

(1). "Benjamin Rush Psychiator," Dr. H. D. Allen, Jr., Milledgeville.

(2). "Pneumonia," Dr. V. P. Sydenstriker, Augusta. Discussed by Dr. W. A. Mulherin; closed by Dr. Sydenstriker.

(3). "Pediatric Vagaries," Dr. W. A. Mulherin, Augusta. Discussed by Dr. H. P. Harrell.

(4). "Pellagra," Dr. Joseph Goldberger, Washington, D. C. Discussed by Drs. G. A. Wheeler, W. A. Mulherin and V. P. Sydenstriker. Closed by Dr. Goldberger.

(5). "Dementia Praecox," Dr. Geo. L. Echols, Milledgeville. Discussed by Drs. H. D. Allen, Jr., Walker, Yarborough and Baines. Closed by Dr. Echols.

(6). "Eye Manifestations in Brain Pathology," Dr. J. M. Hull, Augusta.

(7). "Syphilis of the Insane," Dr. John W. Oden, Milledgeville. Discussed by Dr. W. J. Cranston.

(8). "Brain Injuries," Dr. R. Binion, Milledgeville. Discussed by Drs. L. P. Longino and John Wright. Closed by Dr. Binion.

The following officers were elected for 1926:

President—Dr. J. M. Hull, Augusta.

Vice-President—Dr. Richard Binion, Milledgeville.

Secretary-Treasurer—Dr. F. Lansing Lee, Augusta.

Councillor—Dr. S. J. Lewis, Augusta.

There being no further business the meeting adjourned.

After the meeting the members were entertained with a delightful barbecue in the



male occupation park by the Staff of the Georgia State Sanitarium.

R. C. SWINT, M.D., President.

F. L. LEE, M.D., Secretary.

### FULTON COUNTY MEDICAL SOCIETY

A very interesting meeting of the Fulton County Medical Society was held October 15th, at the Academy of Medicine, 32 Howard St., Atlanta. Dr. Theo. Toepel presided with 78 members present.

Under presentation of patients, Dr. C. H. Holmes showed a case of "Pulmonary Tuberculosis," which was discussed by Dr. E. A. Allen and Dr. C. C. Aven. A case report, "An Unusual Disease of Bones," was read by Dr. W. W. Blackman and discussed by Dr. J. W. Landham. A clinical talk, "My Experiences Abroad," was given by Dr. Louis Holtz. The paper of the evening was presented by Drs. Lake and Hudson, "Importance of Early Diagnosis of Gall Bladder Disease and the Value of Cholecystograms." This was discussed by Drs. E. C. Davis and C. W. Roberts.

Another regular meeting of this Society was held at the Academy of Medicine, Thursday evening, November 5th, at eight o'clock. The president, Dr. Theo. Toepel, presided, and there were 87 members present.

Dr. L. H. Goldsmith reported cases of "Foreign Body Inhalations," which was discussed by Drs. L. D. Hoppe and R. R. Daly.

"Demonstration of Kidney Specimen and X-Ray Photographs" was reported by Drs. W. B. Jones and J. S. Derr. Under clinical talks, Dr. T. J. Collier on "General Anesthesia" and Dr. L. W. Grove on "Local Anesthesia in Abdominal Surgery," and Dr. J. Calvin Weaver on "Local Anesthesia in Head Injuries," and Dr. E. D. Highsmith on "Surgical Correction of the Mouth and Face." These talks were discussed by Drs. Connor, Person, Campbell, Denton, Selman and T. C. Davison.

After the reports from the committees, there being no further business to come before the Society the motion to adjourn was in order.

Respectfully submitted,

GRADY E. CLAY, Secretary,

### THE HABIT OF ATTENDING MEDICAL MEETINGS

Presence at a meeting, hearing discussions and papers not only is of value to the beginner, but has been considered of importance to our masters, says Marcus Feingold, New Orleans (Journal A. M. A., July 11, 1925). Naturally, not all that is transacted in every meeting is of the kind that signifies progress and betterment: some things presented may be of the kind that should be avoided and deprecated. But there is good also in listening to this kind because it teaches how to avoid the mistakes of others. Presence at meetings produces, in different members of the audience, various emotions. These emotions must apparently fall into one or more of the following subdivisions; admiration for the subject or the speaker; feeling of one's own inferiority in having done so little; the desire to imitate that piece of work and that method; the determination not to overlook this or that in the future, and regrets at having failed to observe this and that. Attendance at meetings has often led to ties of the most fruitful and warmest friendships among medical men the world over. History of medicine contains many records of the wonderful effects of exchange of thoughts among friendly spirits, just as these medical meetings. Attendance at meetings must not be limited to those of our immediate circles. The larger the group of individuals banded together, the greater is the probability of valuable and stimulating contributions at that meeting.

### COMMUNICATIONS

To the Editor:

Your letter of October 15, 1925, has been received and I wish to thank you for your courteous reply to my recent inquiries.

I was born in Hungary; graduated from the Royal Hungarian Elizabeth University of Budapest; besides Hungarian Hospital experience I have completed a Class A hospital internship in the United States.

I am thirty years of age; single; six feet one inch tall; in excellent health. I speak the English language fluently in addition to other languages. I am not an atheist but I have no religious or fraternal affiliations. Incidentally, I play the piano well.

The questions arise, how I would be accepted in your state? Is there any possibility of settling without buying a practice, inasmuch as I am without funds? Or, is there a possibility of a partnership with a retiring physician until the required purchase price has been earned?

I am able to furnish the best references any time it is necessary.

Sincerely yours,

T. NORBERT KENDE, M.D.,

Manhattan State Hospital, Ward's Island,  
New York City.

# Woman's Auxiliary of the Medical Association of Georgia

## OFFICERS

President.....Mrs. William H. Myers, Savannah    Secretary-Treasurer.....Mrs. A. J. Mooney, Statesboro  
Vice-President-at-large.....Mrs. C. W. Roberts, Atlanta    Parliamentarian.....Mrs. Allen H. Bunce, Atlanta

## HEALTH WORK IN GEORGIA

T. F. ABERCROMBIE, M.D.\*

Commissioner of Health, State of Georgia  
Atlanta, Ga.

The most important happening in the State of Georgia last year was the birth of 67,081 children. 5,871, or 8% of the 67,081 children, did not live to see their first birthday. There was a total of 38,563 deaths, and 15.2% of the 38,563 never lived to see their first birthday. Besides the number that died the first year of their life hordes of them are handicapped physically or mentally just enough to be drawn into the rank of those who may labor long but receive little happiness or substance. Studies made in many communities indicate that millions of American school children suffer from malnutrition or physical defects, most of which can be prevented and many corrected.

A child born today has an expectation of about 55 years of life. After passing the first few years when the hazards are great the average child who has reached his fifth birthday has a chance of living to be 62 years old. As measured by the death rate the age of least health hazard is from 10 to 14 years.

From 1914 to 1924 great progress has been made in reducing the physical handicaps and the disease hazards of children, in establishing through an infinite number of channels—the schools, health centers, play-grounds—the hope of positive health. Science has made brilliant discoveries which sweep back the enemies to life. The proof of the progress is clear in the saving of the lives of approximately 23 more babies under one year out of every thousand born in 1924

over those saved in 1914. In twenty years our infant mortality has been reduced by half.

The following figures should make us all think: Our country at large spent in 1923, \$1,400,000,000 for hospitals, nurses, healers, and drugs—that was the bill for curing ills, whereas the total expenditure for health, local, State and national was but \$60,000,000. We can expect to waste money with consequent loss of life until we are willing to spend more than 6.10 of 1% of our total Governmental expenditures for the ounce of prevention.

It is estimated that at least 5% of the children of school age, approximately 1,000,000 have been infected with tubercule bacilli showing the presence of tuberculosis infection, although examination of school children rarely reveals 1% with the active disease. From 25 to 40% have defects of posture and foot arches. From 15 to 25% are malnourished. This is largely a preventable defect, and one which health education may help effectively to reduce. In a survey of school children of a large city by the National Committee on Mental Hygiene 13.2% were found mentally abnormal and unstable. Of cases of juvenile delinquency 75.9% were found to be mentally abnormal. Among dependency cases in adults 72.9% were abnormal.

181,817 children repeated grades in Georgia schools in 1924. The average cost per pupil per year is \$15.62. 181,817, the total number of pupils retarded, multiplied by \$15.62 is \$2,839,981.54, showing the enormous loss in money each year spent on repeaters. Assuming that lack of opportunity to go to school, short terms, poor equipment in schools is responsible for one-half of this repeating, there would still be \$1,419,990.77 to

\*Read before the Woman's Auxiliary of the Medical Association of Georgia, May 14, 1925.

Forward this with remittance to your **County** Secretary.

Draft

I enclose Money Order for 1926 County Society dues - - - \$.....

Check

1926 State dues - - - 5.00

Total - - - \$

This must be sent to your **County** Secretary as is stated in the Constitution and By-Laws of the Association. As soon as your State dues are received from your County Secretary we will immediately send you your 1926 membership card, place your name on the mailing list of the Journal and you will begin receiving the benefit of the medical defense feature.

Please co-operate with us by remitting to your County Secretary NOW.

Name .....

Street and Number.....

City .....

ALLEN H. BUNCE, Secretary-Treasurer,  
Medical Association of Georgia.





be accounted for. Mr. W. A. Sutton, Superintendent of the City Schools of Atlanta, has reduced repeating in the city schools by one-half in two years, and his statement is that the physical condition of the child is the prime factor in the child's retardation. He has also reduced this by an intensive health education program in the schools together with a dental hygiene program, school lunch and physical defect correction program. According to his program, he is saving the City Schools of Atlanta this year \$250,000 on repeaters alone. If this can be done for the City of Atlanta, it can be done for the State of Georgia.

The following is a definition of a healthy personality:

1. The child possesses intelligence adequate to meet the demands of his life. This includes the whole range of intelligence from very superior to somewhat below the average. Some very healthy personalities are found among those whose intelligence is inferior to the average, but is nevertheless sufficient to meet the demands of their simple lives of manual work.

2. He is able to concentrate his attention upon the matter before him, and to perceive the important elements of the situation with accuracy and alertness.

3. He is interested in the world about him, and curious to understand it.

4. He is generally self-confident; he expects success and achieves it with reasonable frequency.

5. He is active in overcoming difficulties; he does not "day dream" so much that he fails to meet the actual situation.

6. His predominating emotional qualities are happiness, cheerfulness, courageousness. He is not troubled by unnecessary fears, shyness, or timidity. His emotional responses are those that are appropriate and useful for the occasion.

7. He does not ordinarily brood or sulk, or indulge in morbid introspection.

8. He is companionable and mingles easily with other children. He adapts himself easily to co-operative enterprises; to leadership or fellowship.

9. He has many objective interests; friends, hobbies, games in which he finds adequate self-expression.

10. The child's relationships with children of the opposite sex are wholesome.

11. He has a sense of responsibility for the happiness and wellbeing of his friends, school mates and members of his family.

Contrary to the opinions of many, life in country districts is not especially healthful. Hookworm disease and malaria today are almost entirely of rural origin, there is more typhoid and dysentery in rural communities than in cities, and tuberculosis in the country is surprisingly prevalent. The economic loss due to hookworm, malaria, and typhoid alone is estimated to be more than one billion dollars per year, and this loss falls particularly heavy upon our farming population. During surveys conducted by the United States Public Health Service in 1914 to 1916, 50,000 typical farm homes were visited, and it was found that less than 1.22 per cent of them were provided with sanitary toilets. At 68 per cent of these homes, the water used for drinking was obviously exposed to contamination from privy contents or from promiscuous deposits of human filth.

Rural hygiene is important to the entire nation's health at least for three important reasons: (1) Milk and vegetables coming from rural districts may bring in disease to the cities; (2) the source of most water supplies is in the country; and (3), because of frequent and extensive travel between rural and urban communities, the control of communicable diseases in cities where half of the people live cannot be achieved unless the health of the other half who live in the country is fully supervised.

Some thirty or forty years ago a boy, now an officer of the United States Public Health Service, attended school in a rural community. In winter the school building was kept tightly closed and heated with a large stove in the center. Expectoration on the floor was a frequent indoor amusement. Water was obtained from an unprotected spring below a soil-polluted drainage area, or from an open well exposed constantly to pollution from a nearby or an open privy in a neighboring home.

It was supplied to the children in an open pail, with one common tin dipper. No school toilets were provided; teacher, boys and girls had recourse only to such privacy as

was afforded by the surrounding woods. In 1910, conditions comparable to those existed in a large portion of the small rural schools of the United States.

A program for county health work, according to L. L. Lumsden, should include: (1) quarantine and bedside instructions to prevent the spread of dangerous communicable diseases; (2) instructions in prenatal care and in the hygiene of children of pre-school age; (3) hygiene of schools and other public buildings, and physical examination and physical training of school children; (4) control of soil pollution; (5) control of insects likely to convey infection; (6) safeguarding water and food supplies and giving instructions on the principles of dietetics; (7) life-extension work; (8) organization of local clubs for instruction and training in physical development and general hygiene; (9) anti-tuberculosis work directed especially toward the discovery and encouragement of proper self-treatment of cases of incipient and early-stage tuberculosis; (10) measures for eradication of hookworm disease in Southern states; and (11) educational work, through lectures, printed articles, moving pictures, and other available agencies, concentrated from time to time on different specific disease problems.

For a community with a population of 20,000 or over, an effective program requires the full attention of a health officer, a public health nurse, and a sanitary inspector. For less population a smaller staff may be used.

A comparison of the deaths from typhoid fever in the counties with a full-time health service, as against the mortality from this disease in all other counties in the State, gives some interesting data. Typhoid fever was chosen for this comparison for the reason that its prevalence probably represents more accurately than that of any other communicable disease the status of health conditions in general in the community. Including even those counties which established full-time health organizations only last year, there has been a consistent decrease in deaths from typhoid fever in counties with full-time health service from 154 in 1922 to 126 in 1924, amounting to a reduction of 18 per cent during two years, while in all other

counties combined there was a decrease from 561 to 541, or only a little over 3 per cent for the two years and an **increase** of 86 deaths, or 19 per cent, for 1924 over 1923.

The decrease in mortality from typhoid fever has been very striking in some of the full-time counties, notably Mitchell, where the deaths dropped from 12 to 0 in two years; in Walker, where the number was only 4 in 1922 and 1 in 1924; and in Clarke which had only 6 deaths in 1922 and 3 in 1924, as against 13 in 1921.

#### AUXILIARY TO FIRST DISTRICT MEDICAL ASSOCIATION

The Auxiliary to the First District Georgia Medical Association met in the Medical Hall at Savannah, Ga., August 6, 1925. Mrs. Jas. N. Carter, President of the local auxiliary, presided in the absence of Mrs. A. J. Waring, First District Manager. Mrs. Ralston Lattimore was appointed to serve as Secretary of the meeting.

Dr. John W. Daniel gave an instructive talk on the Ellis Health Bill, and at the conclusion of the talk the Auxiliary made the resolution to endorse the Ellis Health Bill and request the proper authorities to enforce the law in Chatham County. A copy was sent to the County Health Board.

Mrs. John S. Hawkins gave a talk on Parliamentary Law.

Mrs. Wm. H. Myers sang a group of Kentucky folk songs.

An interesting report of the Screven County Auxiliary was given by Mrs. L. F. Lanier, of Rocky Ford.

In the afternoon a tea was given at the Shrine Country Club. Mrs. W. R. Dancy and Mrs. Lloyd B. Taylor were hostesses for the afternoon. The next morning the guests assembled at the DeSoto Hotel and were taken to Tybee in automobiles for the day. A delightful luncheon was served at the Oleander Tea Room. Mrs. Jas. N. Carter was toastmistress, and informal talks were made by Mrs. Wm. H. Myers, Mrs. Ralston Lattimore, Mrs. Lanier, of Rocky Ford, Mrs. Lee Howard, and others.

The next meeting of the Auxiliary will be held in Millen at the same time of the First District Medical Association.



## AUXILIARY TO EIGHTH DISTRICT MEDICAL ASSOCIATION

The Auxiliary to the Eighth District Medical Association met in Athens, Ga., August 12, 1925, at the Memorial Hall. The meeting was called to order by the Eighth District Manager, Mrs. Paul Holliday, of Athens.

After the election of an Acting Secretary, the Invocation was given by Dr. Samuel Cartledge. An address of welcome was given by the President of the Clarke County Auxiliary, Mrs. Paul Holliday. A response was given by Mrs. S. A. Clark, of Eatonton, Ga.

After the roll call of counties, a delightful song was sung by Mrs. Hunter Hubbard. Addresses on Parliamentary Usage by Dr. Joseph Stewart, and Child Health by Dr. Bolling Gay, completed the program. At one o'clock the ladies enjoyed a barbecue dinner given by the doctors.

### Resolutions On the Death of Mrs. R. B. Ridley, Wife of Dr. R. B. Ridley, Atlanta, A Member of the Fulton County Medical Society

When an imperfect flower is gone, we do not lament its loss; but in the garden of life when one in the richness and fragrance of its bloom is blown by the chilling wind of death, our hearts are crushed and we cry as a "babe in the night with no answer, but a cry."

And yet we know that God is good, and in His wisdom has selected the choicest here to enrich the beauty of Heaven, where all is fadeless and perfect, where no sorrow can ever come or any joy depart.

The rare colors of her character blended so modestly into the clear white charm of her winsome personality, that its brightness will ever linger with us, a halo about her memory.

Whereas, in the bestowal of her best, from which she withheld nothing, in all that was exemplary and inspiring in the very wholesomeness of her service to our Organization.

Resolved; That in the death of Mrs. Ridley, The Auxiliary to the Fulton County Medical Association has sustained a loss that is made the keener and the more irretrievable on account of her efficiency as an associate, and the fervency of her gentle spirit as a colaborer in every feature of the work.

We extend our deepest sympathy to her bereaved husband.

Be it further resolved; That a copy of these resolutions be mailed Dr. Ridley, one furnished the Journal of the Medical Association of Georgia and that they be spread on the minutes of this Auxiliary.

### WOMAN'S AUXILIARY TO THE FULTON CO. MED. SOC.

## BOOKS RECEIVED

APPLIED BIOCHEMISTRY, by Winthrow Morse, Ph.D., Professor of Physiological Chemistry and Toxicology, Jefferson Medical College, Philadelphia. Octavo of 958 pages with 257 illustrations. Publishers: W. B. Saunders Company, 1925, Philadelphia and London. Price: Cloth, \$7.00 net.

THORACIC SURGERY, the Surgical Treatment of Thoracic Disease, by Howard Lilienthal, M.D., Professor of Clinical Surgery at Cornell University Medical School. Two Octavo volumes totaling 1294 pages, with 90 illustrations, 10 in colors. Publishers: W. B. Saunders Co., Philadelphia and London. Price: Cloth, \$20.00.

A TEXT-BOOK OF MEDICAL DIAGNOSIS, by James M. Anders, M.D., Professor of Medicine, Medico-Chirurgical College, Graduate School of Medicine, University of Pennsylvania; and L. Napoleon Boston, M.D., Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania. Third Edition, entirely reset. Octavo of 1422 pages, 555 illustrations, some in colors. Publishers: W. B. Saunders, Philadelphia and London. Price: Cloth, \$12.00.

MASSAGE AND THERAPEUTIC EXERCISE, by Mary McMillan, Supervisor of Aids in Physiotherapy, Medical Corps, U. S. A., 1919-20. Second edition, reset. 12mo of 331 pages with 17 illustrations. Publishers: W. B. Saunders Co., Philadelphia and London. Price, \$2.50 net.

CHEMICAL PATHOLOGY, (Being a Discussion of General Pathology from the Standpoint of the Chemical Processes Involved), by H. Gideon Wells, Ph.D., M. D., Professor of Pathology in the University of Chicago and in Rush Medical College,

Chicago; Director of Medical Research in the Otho S. A. Sprague Memorial Institute. Fifth edition, revised and reset. Publishers: W. B. Saunders Co., Philadelphia and London.

**THE THERAPY OF PUERPERAL FEVER**, by Privatdozent Dr. Robert Koehler, formerly Assistant of the Gynecological Department of the Krankenhaus Wieden (Director: Hofrat Professor Dr. Josef Halban) in Vienna, Austria. American Edition prepared by Hugo Ehrenfest, M.D., F.A.C.S., Associate in Obstetrics, Washington University School of Medicine, Obstetrician and Gynecologist of the Jewish Hospital, Consulting Obstetrician to St. Louis Maternity Hospital, St. Louis. 27 Illustrations. Publishers: C. V. Mosby Co., St. Louis, Mo. Price, \$4.00.

**A TEXTBOOK OF PHYSIOLOGY**, by William D. Zoethout, Ph.D., Professor of Physiology in the Chicago College of Dental Surgery (Loyola University) and in the Chicago Normal School of Physical Education. Second edition. Publishers: C. V. Mosby Co., St. Louis, Mo. Price, \$4.50.

**1926 PHYSICIANS VISITING LIST**. 60 Patients per week size. Dosage tables, etc., have been carefully revised to conform to the recent revision of the U. S. Pharmacopeia. The Visiting List is also supplied in 30 and 90 patient sizes. Price, \$2.00. Publishers: William Wood & Company, New York.

**INSECTS AND DISEASE OF MAN**, by Carroll Fox, M.D., Surgeon, U. S. Public Health Service. 92 illustrations. 8vo. 249 pages plus XII. Publishers: P. Blakiston's Son & Co., Philadelphia. Price, Cloth \$4.00.

## Book Reviews

### **INSECTS AND DISEASE OF MAN**

**By Carroll Fox, M.D., Surgeon, U. S. Public Health Service. Publishers: P. Blakiston's Son & Co., Philadelphia.**

This is a thoroughly practical work on medical entomology, and is intended for the Field Health Officer, Physicians, Entomolo-

gists, and others. The first part deals with the Classification, Identification, Anatomy, Life History, General Considerations, Key to Sub-families, etc., together with a chapter on Arachnida and Rodents and Notes on technique.

Part II discusses the diseases carried by Anthropods among human beings. Under each disease is given the Causative Agent; Source of Infection; Mode of Transmission; Period of Incubation, Communicability; Epidemiology, etc.; Recognition of the Disease, Prevention and Control, Treatment of Carriers, Prophylaxis and all practical points including the smaller details, such as the articles required, detailed instruction in the preparation of material, and the investigations to be made by the field worker. The author has had considerable experience in the U. S. Public Health Service and has written a book which is truly practical in all respects.

### **ELECTRO-THERAPY AND IONIC MEDICATION**

**A Technical and Clinical Compendium, by Harold H. U. Cross, Ph.D., (Med.), Formerly Research Worker at the Stanford University, California.... Publishers: J. B. Lippincott Co., Philadelphia.**

In offering this little manual of Medical Electricity to the profession, it has been the author's aim to supply just such technical information as will show the student and the practitioner the underlying electrical and chemical principles of the subject, in order that an intelligent interest may be taken in the selection and use of the various forms of apparatus and methods of treatment now so generally available.

The first two chapters are devoted to the exposition of first principle, and is meant for the physicians who have not previously acquired any electrical education, and are, therefore, totally unacquainted with electro-technics. Chapters III and IV describe typical apparatus without the interposition of the fundamental technicalities explained in the earlier portion, attention being drawn only to points of special electrical or chemical interest.



Particular attention is invited to the chapters on Ionic Medication, as much of this material appears for the first time, and is the outcome of many years' work in that field, both in the clinic and in the laboratory. The chapter devoted to the visibility of ionic penetration previously appeared as a contribution to the Archives of Radiology and Electrotherapy, and embodies some of the work done by the author in the laboratory provided by the generosity of the Stanford University, California.

Contents: Introduction, the Mechanics of Electro-Therapeutics, Electro-Medical Installations, Magnetism and Electricity, their Simpler Applications to Medicine, the Principles and Practice of Electrolysis, Ions and Ionic Medication, the High Frequency Current, Roentgen Ray Notes, the Electrical Treatment of Cancer.

### MARRIAGES

Mr. and Mrs. Edward McIntosh Willingham have announced the marriage of their daughter, Anna Kirby, to Dr. William Walter Young. Dr. and Mrs. Young are now living at 108 Oakdale Road, Atlanta. Dr. Young is a member of the Fulton County Medical Society and has offices at 41 Forrest Avenue.

### OBITUARY

Dr. John Hubert Troutt, 57 years of age, died at his home in Madison, Sunday morning, November 1, 1925. He had been in failing health for several years but his condition did not become serious until a month previous to his death. Dr. Troutt was born in Jefferson, Georgia, and graduated from the Medical Department of the University of Georgia, Augusta, in 1885. He then began his practice in his home town and remained there until 1900, when he removed to Madison. Dr. Troutt was a member of the Morgan County Medical Society, a Mason, member of the Yarrab Temple, Atlanta, Madison Kiwanis Club, Morgan County Board of Education and the Pennington Methodist Church.

He is survived by his wife, three sons: Nat, of Atlanta; L. H., of Savannah, and Hubert, of Madison; his father, N. G. Troutt, of Pendergrass; a sister, Mrs. E. A. Caldwell, of Monroe, and two brothers, J. R. Troutt, of Oakland, Miss., and Hoke Troutt, of Gainesville.

Dr. Thos. E. Mitchell, a prominent and beloved physician of Columbus, died at a private sanitarium in Atlanta, Friday, November 6, 1925. The body was taken to Columbus for interment. Dr. Mitchell was 60 years of age and an outstanding member of the Muscogee County Medical Society.

Dr. Henry B. Allen died at the age of 46 at his home in Americus. He had an attack of influenza which developed into pneumonia five days later, causing his death. Dr. Allen removed to Americus several years ago from Andersonville, S. C. Burial took place in Sandersville, his wife's home, who was formerly Miss Mary Joyner. Besides his widow he is survived by two daughters. Dr. Allen was a member of the Sumter County Medical Society and a past head consul of the Woodmen of the World in Georgia.

Dr. J. Lawton Hiers died suddenly Sunday night, November 8, 1925, at his home in Savannah. The funeral was held at the Second Baptist Church, Savannah. Drs. L. A. DeLoach and Chas. Usher were among the active pallbearers and Drs. J. O. Baker and G. H. Johnson were among the honorary pallbearers. The members of the Chatham County Medical Society, of which Dr. Hiers was a prominent member, met in a body and attended the services. Dr. Hiers has the distinction of performing the first and last operations at the Park View Sanitarium, Savannah, both of which were tonsillectomies. This so happened as the Park View was recently closed.

### ALL IN FIFTY YEARS

Generally speaking a man fifty years of age has slept 6,000 days, worked 6,500 days, walked 800 days, amused himself 4,000 days, eaten 1,500 days and has been sick 500 days. He has eaten 17,000 pounds of bread, 16,000 pounds of meat and 4,600 pounds of vegetables, eggs and fish and drunk in all 7,000 gallons of liquid.



# Medical Progress

## Department Editors

Anderson, W. W., Pediatrics  
Ballenger, E. G., Urology  
Bartholomew, R. A., Obstetrics  
Block, E. B., Neurology and Psychiatry  
Clay, Grady E., Ophthalmology  
Dowman, C. E., Neuro-Surgery  
Eggen, M. S., Otology, Laryngology and Rhinology  
Fitts, Jno. B., Internal Medicine  
Greene, E. H., Surgery

Hodgson, F. G., Orthopedics  
Holmes, Walter R., Gynecology and Female Urology  
Jones, Jack W., Dermatology  
Klugh, Geo. F., Clinical Pathology  
Landham, J. W., X-Ray and Radium  
Pruitt, M. C., Proctology  
Thrash, E. C., Internal Medicine  
Waits, C. E., Surgery

### INTRACRANIAL TUMORS

Charles Edward Dowman, M.D.  
Atlanta, Ga.

(Continued from November issue)

#### TUMORS OF THE MOTOR CORTEX:

It has been mentioned that the motor cortex is located in the convolution just in front of the Rolandic fissure, and extends over on the adjacent mesial surface of the brain. Tumors of this region are perhaps the easiest to localize. The symptoms are contralateral motor manifestations and may be either purely irritative or purely paralytic, or a combination of both, depending upon whether the lesion is purely irritative or whether actual destruction of motor cells and fibres has taken place.

The manifestations of an irritative lesion are localized jacksonian movements commencing in the contralateral arm, hand, leg, foot or face, depending upon which of these centers is directly implicated. The movements consist of tonic spasm followed by clonic jerks and may be confined to a very small group of muscles, or they may spread to other groups of muscles. Such fits always assume the same progression. The patients usually retain consciousness and are able to accurately describe the progression of the spasm, and in which particular group of muscles it began. When the irritation spreads over to the opposite side of the brain the patient loses consciousness and the convulsive movements become general. In this latter condition, however, it is often possible to obtain the history of a localized jerking before the general involvement. Such a history, when obtained, has enormous localizing value.

When the lesion becomes destructive, in addition to the irritative phenomena there occurs a definite paresis, either transient (after the attacks of jerking) or permanent, of certain movements according to the extent of the lesion. When a tumor is primarily cortical, as for example, an endothelioma of the meninges directly over some part of the motor cortex, the manifestations will remain of a purely irritative char-

acter until the pressure of the growth actually causes a cessation of function of the underlying cortex. When this occurs there will occur, in addition to the irritative phenomena, an actual paresis of the involved extremity. A subcortical tumor, on the other hand, will usually give rise to a paresis of the involved regions from the very beginning, and this paresis usually precedes the appearance of the irritative symptoms. The attacks of jerking do not always progress in the same order in subcortical growths. For example, in one attack the shoulder muscles may be the first to jerk, whereas in another attack the face may be the first area showing conclusive movements. The deeper the subcortical location of the growth the less the tendency to localized convulsions. If the growth is entirely in the precentral region there may be no sensory disturbances whatsoever. If, however, the growth extends backwards either directly or through pressure such sensory manifestations as an astereognosis and disturbance of joint sense may be present in the contralateral extremities. Should there be pressure on the fibres coming from Broca's area there may occur a partial or complete motor aphasia. Under such circumstances, words will come sluggishly or are slurred. When a tumor is located rather low on the side of the speech centers, pressure may be exerted on the superior temporo-sphenoidal gyrus, causing inaccuracies of name and description rather than difficulties of articulation. Should a subcortical tumor be so deep as to impinge on the optic thalamus there will occur a loss of the emotional movements on the opposite side of the face in addition to a diminution of all types of sensations on the opposite side of the body. It should be kept in mind that when the sensory cortex and not the optic thalamus is involved there will be no marked disturbance of such sensations as touch and pain.

**TUMORS OF THE POST-CENTRAL CONVOLUTIONS:** It must be kept in mind that the cortex of the parietal lobe, particularly that portion directly posterior to the Rolandic fissure, is the area in which are

registered the so-called psychotactile sensations rather than such crude sensations as touch and pain. These latter as well as the primitive emotions are registered in the optic thalamus which is the great subcortical sensory center. From the optic thalamus there are transmitted up to the sensory cortex those sensations which have to do with the recognition of length, breadth, and thickness, spatial relationship, the recognition of objects placed in the hands, the appreciation of differences in the weight, smoothness or roughness of objects felt, the recognition of the position of the fingers, toes, etc.; (joint sense and sense of position). A tumor involving the postcentral area will therefore give rise to such localizing symptoms as astereognosis, loss of joint sense, loss of sense of position, adiadokokinesia, inability to determine the exact spot touched, inability to appreciate the two points of a compass, etc., in the contralateral extremities. Should the lesion be cortical there will usually be obtained a history of paresthesia (numbness, tingling, etc.) in the involved extremities. The sense of touch and pain is not destroyed unless the tumor is subcortical and so deeply placed as to press on the optic thalamus. When the growth involves directly or indirectly through pressure, the precentral area, there may occur also some of the findings and symptoms mentioned under Tumors of the Motor Cortex.

When there is a tumor of the inferior part of the parietal lobe on the side of the various speech centers, the symptoms are practically those which might be caused by a disturbance of the association paths connecting the center for the memory of spoken languages and sounds (located in the temporal lobe), the center for the memory of words and objects seen (angular gyrus) and the motor speech center (Broca's convolution). These symptoms are principally varying degrees of motor, auditory, and visual aphasia, in addition to some such findings as astereognosis, loss of joint sense, etc., caused by disturbance of the fibres going to the postcentral cortex. On account of the aphasia such patients are not infrequently classified among the insane, a mistake which should not be made if a thorough neurological as well as a psychiatric examination be made.

**TUMORS OF THE OCCIPITAL LOBES:** The cortical centers of sight are represented on the mesial surface of the occipital lobe above and below the calcarine fissure. The center in each occipital lobe receives sight impulses from each eye, and is in reality a half vision center. The impulses reaching the right occipital lobe come from the right

half of each retina, for example, and are the images seen to the left of central vision. The impulses from the lower right quadrant of each retina are registered in that part of the cortex below the right calcarine fissure (lingual gyrus) and those from the upper quadrant are registered in the cortex above the right calcarine fissure (cuneus labula). In terms of "visual field", therefore, objects seen in the left upper quadrant are registered in the cortex below the right calcarine fissure, etc. Tumors of the occipital lobe give rise to irritative or paralytic symptoms according to whether the visual cortex is being irritated, or whether the cortex or connecting fibres are destroyed (either actually or functionally). If the symptoms are the result of irritation there will occur in the contralateral visual field of both eyes visual jacksonian attacks, characterized by flashes of light which lack the constructive quality so characteristic of the visual hallucinations which may result from deep-seated tumors of the temporal lobe (c.f. tumors of temporal lobe). The attacks are usually followed by a homonymous hemianopsia of temporary duration. As the expanding lesion produces more and more pressure, the hemianopsia gradually becomes permanent. The anopsia will be quadrantic or hemi, according to whether or not the area above or below the calcarine fissure is involved or the whole half vision center is involved. The subcortical growths are usually destructive and may give rise to contralateral hemianopsia with or without preceding visual irritative phenomena. Not infrequently occipital lobe tumors will press downward on the tentorium and will cause symptoms of asynergia due to indirect involvement of the underlying cerebellum.

#### **TUMORS OF THE CENTRAL GANGLIA: (THALAMUS AND CORPUS STRIATUM).**

The functions of these subcortical sensory and motor centers have already been alluded to. On account of their close proximity to each other and to the internal capsule it can be readily understood why all of these structures are liable to be involved in a tumor of any appreciable size in this area. In spite of the known functions of these structures, tumors in this locality are not always easy to localize. The findings usually present are a slowly progressive contralateral hemiplegia, a contralateral hemianesthesia, and a contralateral homonymous hemianopsia. On account of the optic thalamus being a lower reflex center for the emotions, these patients may have a loss of emotional movements on the contralateral side of the face with no paralysis of the voluntary facial movements. Stroking the paralysed extremities may give rise either to great pain



or pleasure in thalamic lesions. When the corpus striatum is involved there may occur choreiform or athetoid movements of the contralateral limbs (intensified on exertion) and on account of the close proximity of the spino-rubral tracts there may be present a coarse rhythmic tremor of the contralateral extremities. In addition to the hemianesthesia there may occur paroxysms of pain in the paralysed extremities when the lesion is irritative. Unless the internal capsule is affected the plantar reflexes will be flexor and not extensor in type.

#### TUMORS OF THE CORPUS COLLOSUM:

The corpus collosum is composed of the so-called commissural fibres connecting the two cerebral hemispheres. Tumors involving this structure usually produce a slowly progressive quadriplegia without involvement of the cranial nerves except those which may be affected by the increased intracranial pressure due to the occlusion of the foramen of Monro and the subsequent internal hydrocephalus. An extensive interference causes a blurring of intelligence. When these symptoms are produced it is the anterior half of the corpus collosum which is involved, since it has been demonstrated that the posterior half of the corpus collosum can be severed in approaching (by operation) tumors of the third ventricle without producing any symptoms whatsoever. When motor symptoms are present it is usually due to extension of the tumor into surrounding structures. When the tumor extends downward into the third ventricle the foramina of Monro become obstructed and an internal hydrocephalus results. Without air injection into the ventricle with X-Ray studies, these tumors can hardly be diagnosed. Should, however, air injection reveal an obstruction of the interventricular foramina (Monro) a tumor of the corpus collosum should be suspected, especially if there are no symptoms suggesting pineal gland tumor.

**TUMORS OF THE CORPORA QUADRIGEMINA AND PINEAL BODY:** Some reference has already been made to the symptoms of lesions of the corpora quadrigemina when deep-seated tumors of the temporal lobe were discussed. As tumors of the corpora quadrigemina almost always arise in the pineal body, they consequently usually occur in young individuals. The glandular manifestations of pineal gland tumors are those of precocious sexual development. I remember seeing a boy of six years of age, who had such a tumor, whose sexual organs were fully developed and the patient's main pastime was masturbation which resulted in emissions. His voice was coarse like a man's. The glandular manifestations in pineal tu-

mors are reverse of those produced by some pituitary tumors. It is possible, however, to have a tumor of the pineal body coming on later in life. In such cases there are no symptoms of the above nature. Such tumors compress neighboring structures, and those most likely to be thus involved are the corpora quadrigemina. As important eye reflex centers are located in the corpora quadrigemina, tumors in this region can usually be localized by the characteristic ocular findings. These consist of a bilateral third nerve paralysis which causes a sluggishness or absence of the pupillary reflexes, a bilateral ptosis, and a weakness of convergence and of upward and downward movements of the eyes. If the posterior corpora quadrigemina are involved there may be deafness, as the subcortical auditory centers are located in these structures. When the superior cerebellar peduncles are pressed upon, the patient will have a reeling gait and other cerebellar manifestations. Pressure upon the external geniculate body may cause various types of anopsia. When the tumor is large there will occur more or less pressure on both pyramidal tracts with the resulting loss of the abdominal reflexes, the exaggeration of the deep reflexes, and the pressure of a bilateral Bolinski reflex. As these tumors are located in the third ventricle there occurs a blocking of the ventricular drainage with the resulting internal hydrocephalus.

---

#### WANTED—E. E. N. & T. MAN

Excellent opening for an eye, ear, nose and throat doctor in city of 15,000 as an associate or to take over entire charge of office for several months. No competition, whatsoever. Address: "H. B.", care the Journal, 65 Forrest Ave., Atlanta.

---

#### WANTED—ASSISTANT UROLOGIST

An Atlanta Urologist desires an assistant. Must be competent and interested in this branch. For further information address: "Urologist," care the Journal.

---

#### WANTED—TWO PHYSICIANS

Two single physicians, recent graduates with hospital experience for Internes at Ga. State Sanitarium, Milledgeville. Salary \$1200 to \$1500 and board. Opportunity for promotion. For further information, write to Dr. R. C. Swint, Supt., Milledgeville, Ga.



# Directory of the Medical Association of Georgia for 1925

**ALTAMAHA SOCIETY****Members**

Comas, P. H., Baxley

**BALDWIN COUNTY****Officers**

President.....Walker, N. P.  
Vice-President.....Scott, W. M.  
Secy.-Treas.....Allen, H. D., Jr.  
Delegate.....Echols, Geo. L.

**Members**

Allen, E. W., Milledgeville  
Allen, H. D., Sr., Milledgeville  
Allen, H. D., Jr., Milledgeville  
Allen, W. H., Milledgeville  
Anderson, Sam A., Milledgeville  
Binion, Richard, Milledgeville  
Bowen, U. S., Milledgeville  
Bradford, R. W., Milledgeville  
Cox, C. G., Milledgeville  
Echols, Geo. L., Milledgeville  
Garrard, J. I., Milledgeville  
Hall, T. M., Milledgeville  
Key, F. P., Green Cove Springs,  
Fla.

Little, Y. A., Milledgeville  
Longino, L. P., Milledgeville  
Oden, Jno. W., Milledgeville  
Pettit, J. K., Thiels, N. Y.  
Rankin, D. T., Milledgeville  
Saye, E. B., Milledgeville  
Scott, W. M., Milledgeville  
Swint, R. C., Milledgeville  
Thomas, N. R., Albany  
Walker, N. P., Milledgeville  
Yarbrough, Y. H., Milledgeville

**BANKS COUNTY****Members**

Castellaw, Geo. O., Maysville  
Deadywyler, M. P., Maysville  
Harden, O. N., Cornelia  
Jolly, J. S., Homer

**BARROW COUNTY****Officers**

President.....Randolph, W. T.  
Vice-Pres.....Hodges, L. W.  
Secy.-Treas.....Mathews, W. L.

**Members**

Almond, C. B., Winder  
Bowdoin, W. H., Statham  
Harris, E. R., Winder  
Hodges, L. W., Winder  
Mathews, W. L., Winder  
Randolph, W. T., Winder  
Tramel, J. R., Statham

**BARTOW COUNTY****Officers**

President.....Lowry, T.  
Vice-President.....Bradford, H. B.  
Secy.-Treas.....Wofford, W. E.  
Delegate.....Wofford, W. E.

**Members**

Adair, R. E., Cartersville  
Banks, G. T., Pine Log  
Bowdoin, J. P., Adairsville  
Bradford, H. B., Pine Log  
Burton, R. E., Kingston  
Ellis, Chas. L., Kingston  
Felton, Howard E., Cartersville  
Griffin, W. C., Cartersville  
Horton, A. L., Taylorsville  
Howell, S. M., Cartersville  
Lowry, T., Cartersville

Monroe, D. H., Emerson  
McGowan, Hugh S., Cartersville  
Vaughn, W. B., White  
Wilson, R. E., Cartersville  
Wofford, W. E., Cartersville

**BEN HILL COUNTY****Officers**

President.....Coffee, W. P.  
Vice-President.....Russell, E. A.  
Secy.-Treas.....Osborne, L. S.  
Delegate.....Dorminy, E. J.

**Members**

Coffee, W. P., Fitzgerald  
Dorminy, E. J., Fitzgerald  
Dorminy, W. D., Fitzgerald  
Luke, J. M. J., Fitzgerald  
Osborne, L. S., Fitzgerald (Hon.)  
Russell, E. A., Fitzgerald  
Ward, Frank, Fitzgerald  
Ware, D. B., Fitzgerald  
Ware, R. M., Fitzgerald  
White, T. E., Fitzgerald

**BERRIEN-LANIER COUNTIES****Members**

Hamilton, C., Ray City  
Sloan, W. D., Stockton

**BIBB COUNTY****Officers**

President.....Bashinski, Benj.  
Vice-President.....Thompson, O. E.  
Secy.-Treas.....Weaver, H. G.  
Delegate.....Richardson, C. H., Jr.  
.....Ridley, C. L.

**Members**

Adams, I. H., Macon  
Adams, J. Fred, Macon  
Anderson, C. L., Macon  
Anderson, J. C., Macon  
Andrew, James, Banner Mines,  
Littleton, Ala.

Barrow, H. L., Macon  
Bashinski, B., Macon  
Bazemore, W. L., Macon  
Blackshear, T. E., Macon  
Brown, J. F., Lizella  
Carswell, N. T., Macon  
Cater, R. L., Jr., Macon  
Clark, M. A., Macon  
Clay, J. E., Macon  
Coleman, Y. R., Macon  
Corn, Ernest, Macon  
Coward, J. W., Walden  
Daniel, Orman, Macon  
DuPree, G. W., Gordon  
Fountain, J. A., Macon  
Garrard, J. A., Roberta  
Gostin, B. S., Macon  
Greene, B. W., Macon  
Hall, T. H., Macon  
Harrington, F. Y., Macon  
Harris, E. C., Macon  
Harrold, C. C., Macon  
Hembree, J. A., Macon  
Henderson, D. T., Macon  
Hinton, C. C., Macon  
Holmes, J. P., Macon  
Hurley, T. A., Macon  
Jemison, A. B., Milledgeville  
Johnson, B. M., Casey, Iowa  
Johnson, J. E. L., Roberta  
Kay, J. B., Byron  
Keen, O. F., Macon  
Kemp, A. P., Macon  
King, J. L., Macon  
Martin, J. W., Macon

Massenburg, G. Y., Macon  
Meriwether, W. W., Macon  
Miller, G. T., Macon  
Mitchell, F. B., Macon  
Mobley, W. E., Macon  
Moses, Harry, Macon  
Muckenfuss, R. S., Rockefeller  
Inst., New York

McAfee, J. C., Macon  
McAfee, L. C., Macon  
Newman, W. A., Macon  
Newton, R. G., Macon  
Palmer, S. B., Macon  
Pate, J. C., Tampa, Fla.  
Peavy, H. J., Miami, Fla.  
Pennington, C. L., Macon  
Post, W. G., St. Petersburg, Fla.  
Respass, H., Macon  
Richardson, C. H., Jr., Macon  
Ridley, C. L., Macon  
Rogers, T. E., Macon  
Ross, J. T., Macon  
Rozar, A. R., Macon  
Sigman, J. M., Macon  
Solomon, H. D., St. Petersburg,  
Fla.

Spivey, O. S., Macon  
Stapler, M. M., Macon  
Stovall, R. H., Ft. Lauderdale, Fla.  
Thompson, O. R., Macon  
Walker, C. H., Macon  
Walker, D. D., Macon  
Walker, T. D., Jr., Macon  
Ward, J. B., Macon  
Weaver, H. G., Macon  
Weaver, O. H., Macon  
Webb, F. L., Macon  
White, W. S., Ft. Valley  
Williams, W. A., Macon  
Winship, Herring, Macon  
Wright, J. E., Macon

**BLUE RIDGE SOCIETY****Officers**

President.....Daves, J. M.  
Vice-President.....Goss, N. C.  
Secy.-Treas.....Crawford, C. B.  
Delegate.....Crawford, C. B.

**Members**

Crawford, C. B., Blue Ridge  
Daves, J. M., Blue Ridge  
Goss, N. C., Ellijay  
Rogers, W. H., Young Cane  
Tankersley, J. S., Ellijay  
Wellborn, C. J., Blairsville

**BROOKS COUNTY****Officers**

President.....Dorough, G. D.  
Secy.-Treas.....McMichael, J. R.

**Members**

Dorough, G. D., Quitman  
Jelks, E. L., Quitman  
Mathews, W., Quitman  
Moye, T. R., Quitman  
McMichael, J. R., Quitman  
Smith, L. A., Quitman

**BULLOCH-CANDLER COUNTIES****Officers**

President.....Temples, A.  
Vice-President.....Miller, Clifford  
Secy.-Treas.....Floyd, F. F.

**Members**

Bowen, A. J., Portal  
Cone, R. L., Statesboro  
Deal, B. A., Statesboro  
Deal, D. L., Statesboro

Floyd, F. F., Statesboro  
 Floyd, W. E., Statesboro  
 Hilliard, C. W., Statesboro  
 Jones, B. B., Metter  
 Kennedy, R. L., Metter  
 Kennedy, W. D., Metter  
 Lively, M. M., Statesboro (Hon.)  
 Miller, Clifford, Portal  
 Mooney, A. J., Statesboro  
 McElveen, J. M., Brooklet  
 Nevil, J. C., Register  
 Nevil, J. L., Metter  
 Olliff, H. H., Register  
 Patrick, J. Z., Pulaski  
 Quattlebaum, A. W., Statesboro (Hon.)  
 Simmons, W. E., Metter  
 Stapleton, C. E., Groveland  
 Stewart, J. A., Portal  
 Temples, A., Statesboro  
 Watkins, E. C., Brooklet  
 Whiteside, J. H., Statesboro  
 Woods, W. D., Portal

**BURKE COUNTY****Officers**

President.....Lowe, W. R.  
 Vice-President.....Cook, J. M.  
 Secy.-Treas.....Lewis, J. B.  
 Delegate.....McCarver, W. C.

**Members**

Bent, H. F., Midville  
 Byne, J. M., Waynesboro  
 Carpenter, Geo. L., Wrens  
 Cook, J. M., Sardis  
 Hillis, W. W., Sardis  
 Kelley, U. H., Waynesboro  
 Lewis, J. B., Waynesboro  
 Lowe, W. R., Midville  
 Macaulay, H. A., Waynesboro  
 McCarver, W. C., Vidette  
 Miller, R. L., Waynesboro  
 Morton, H. J., Waynesboro  
 Royal, L. B., Girard  
 Smith, B. H., Keysville  
 Sutton, W. H., Midville  
 Torbit, A. M., Gough

**BUTTS COUNTY****Officers**

President.....White, A. F.  
 Vice-President.....Howell, O. B.  
 Secy.-Treas.....Byron, J. Lee  
 Delegate.....White, A. F.

**Members**

Akin, B. F., Jenkinsburg  
 Byron, J. L., Jackson (Hon.)  
 Copeland, H. W., Jackson  
 Hammond, Robt. L., Jackson  
 Harter, J. W., Muscle Shoals, Ala.  
 Howell, O. B., Jackson  
 Steele, W. H., Griffin  
 White, A. F., Flollia

**CAMPBELL COUNTY****Officers**

President.....Busey, T. J.  
 Vice-President.....Jones, A. B.  
 Secy.-Treas.....Green, A. J.  
 Delegate.....Camp, R. T.

**Members**

Bullard, T. P., Palmetto  
 Busey, T. J., Fayetteville  
 Camp, R. T., Fairburn  
 Camp, W. R., Fairburn  
 Green, A. J., Union City  
 Hobgood, L. M., Fairburn  
 Jones, A. B., Tyrone

**CARROLL COUNTY****Officers**

President.....Styles, O. R.  
 Vice-President.....Burnett, G. W.  
 Secy.-Treas.....Fitts, C. C.  
 Delegate.....Griffin, Claude

**Members**

Aderhold, W. A., Carrollton  
 Baskin, C. L., Temple  
 Burnett, G. W., Whitesburg (Hon.)  
 Fitts, C. C., Carrollton  
 Goodwyn, H. J., Carrollton  
 Griffies, J. C., Burwell  
 Griffin, Claude, Carrollton

Hammond, G. W., Roopville  
 Kirby, E. G., Bowdon  
 Lovvorn, J. L., Bowdon  
 Nutt, J. J., Bowdon  
 Powell, B. C., Villa Rica  
 Powell, John E., Villa Rica  
 Reese, D. S., Carrollton  
 Reeves, T. W., Carrollton  
 Roberts, O. W., Carrollton  
 Rogers, T. E., Waco  
 Scales, S. F., R. F. D., Carrollton  
 Smith, W. P., Bowdon  
 Styles, O. R., Bowdon  
 West, Grover, Roopville  
 Wilson, L. E., Bowdon

**CHATHAM COUNTY****Officers**

President.....Train, J. K.  
 Vice-President.....Dancy, W. R.  
 Secy.-Treas.....Morrison, A. A.  
 Delegate.....Exley, H. T.  
 Delegate.....Bean, J. R.

**Members**

Baker, J. O., Savannah  
 Barrow, Craig, Savannah  
 Bassett, V. H., Savannah  
 Bean, J. R., Jacksonville, Fla.  
 Blake, H. H., Savannah  
 Bray, S. E., Savannah  
 Buchanan, D. J., Savannah  
 Carter, J. N., Savannah  
 Chisolm, J. F., Savannah  
 Cole, W. A., Savannah  
 Compton, H. T., Savannah  
 Corson, E. R., Savannah  
 Crawford, W. B., Savannah  
 Dancy, W. R., Savannah  
 Daniel, J. W., Savannah  
 DeCaradenc, St. J. R., Savannah  
 DeLoach, L. A., Savannah  
 Demmond, E. C., Savannah  
 Drane, Robt., Savannah  
 Edwards, D. B., Savannah  
 Egan, M. J., Savannah  
 Egloff, G. E., Savannah  
 Exley, H. T., Savannah  
 Faggart, G. H., Savannah  
 Gleaton, E. N., Savannah  
 Graham, R. E., Savannah  
 Graves, J. R., Miami, Fla.  
 Groover, J. R., Savannah  
 Harris, R. V., Savannah  
 Hawkins, J. S., Savannah  
 Hesse, H. W., Savannah  
 Hiers, J. L., Savannah  
 Holton, C. F., Savannah  
 Howard, Lee, Savannah  
 Iseman, E., Savannah  
 Johnson, G. H., Savannah  
 Jones, Jabez, Savannah  
 Jones, J. P., Savannah  
 Lang, G. H., Savannah  
 Lattimore, R., Savannah  
 Lee, Lawrence, Savannah  
 Lexington, H. L., Savannah  
 Martin, H. H., Savannah  
 Martin, R. V., Savannah  
 Massoud, M. A., Pineora  
 Meldrim, C. H., Savannah  
 Morrison, A. A., Savannah  
 Morrison, J. E., Savannah  
 Myers, W. H., Savannah  
 McGee, H. H., Savannah

(Deceased)

Norton, W. A., Savannah  
 Olmstead, G. T., Savannah  
 O'Neill, J. C., Savannah  
 Osborne, E. S., Savannah  
 Paris, W. E., Savannah  
 Quattlebaum, J. K., Savannah  
 Redmond, C. G., Savannah  
 Reid, R. S., Savannah  
 Righton, H. Y., Savannah  
 Shaw, L. W., Savannah  
 Shearouse, H. W., Savannah  
 Smith, W. K., Pembroke  
 Smith, W. W., Clyo  
 Tarver, H. R., Guyton  
 Taylor, L. B., Savannah  
 Thomas, M. R., Savannah  
 Tippins, H. L., Savannah  
 Touchton, G. L., Savannah  
 Train, J. K., Savannah  
 Usher, Chas., Savannah  
 Usher, J. A., Savannah  
 Usher, Sheddie, Savannah  
 Wahl, Frederick, Savannah  
 Waring, A. J., Savannah

Waring, T. P., Savannah  
 Waters, L. T., Savannah  
 White, G. R., Clinton, S. C.  
 Williams, L. W., Savannah  
 Wilson, W. S., Savannah

**CHATTOOGA COUNTY****Officers**

President.....Talley, R. E.  
 Vice-President.....Bryant, W. J.  
 Secy.-Treas.....Hair, W. B.

**Members**

Brown, H. D., Summerville  
 Bryant, W. J., Summerville  
 Clements, J. W., Gore (Hon.)  
 Hair, W. B., Summerville  
 Hall, F. W., Summerville  
 Jennings, D. M., Menlo  
 Mallicoat, L. A., Trion  
 Martin, G. F., Menlo  
 Medlin, W. B., Miami, Fla.  
 Shamblin, B. F., Lyerly  
 Talley, R. E., Trion  
 Wood, M. N., Menlo

**CHEROKEE COUNTY****Officers**

President.....Bates, J. M.  
 Vice-President.....Harbin, S. R.  
 Secy.-Treas.....Brooke, Geo. C.  
 Delegate.....Brooke, Geo. C.

**Members**

Bates, J. M., Canton  
 Boring, Jas. R., Canton  
 Brooke, Geo. C., Canton  
 Coker, Grady, Canton  
 Coker, N. J., Canton  
 Harbin, S. R., Canton  
 Harbin, D. A., White (Deceased)  
 Moore, R. M., Waleska  
 Pettit, J. T., Canton  
 Vansant, T. J., Woodstock

**CLARKE COUNTY****Officers**

President.....Reynolds, H. I.  
 Vice-President.....Decker, C. J.  
 Secy.-Treas.....Gay, T. B.  
 Delegate.....Goss, R. M.

**Members**

Applewhite, J. D., Athens  
 Birdsong, H. W., Athens  
 Bloomfield, J. C., Athens (Hon.)  
 Cabaniss, W. H., Athens  
 Canning, G. T., Athens  
 Carlton, W. A., Athens (Hon.)  
 Chandler, B. B., Athens  
 Coffee, H. D., Milwaukee, Wis.  
 Colic, F. W., Winterville  
 Deaver, E. S., Lexington  
 Decker, C. J., Athens  
 Fullilove, H. M., Athens  
 Gay, Thos. Bolling, Athens  
 Gerdine, Linton, Athens  
 Goss, R. M., Athens  
 Green, W. L., Crawford  
 Holliday, A. C., Athens  
 Holliday, J. C., Athens  
 Holliday, P. L., Athens  
 Hubert, M. A., Athens  
 Hunnicutt, J. A., Jr., Athens  
 Matthews, M. F., Athens  
 McKinney, J. C., Athens  
 Middlebrooks, C. O., Athens  
 Rayle, A. A., Athens  
 Reynolds, H. I., Athens  
 Smith, S. S., Athens  
 Stewart, J. S., Jr., Athens  
 Whelchel, G. O., Athens  
 Whitley, L. L., Crawford

**CLAYTON-FAYETTE COUNTIES****Officers**

President.....Wallis, G. W.  
 Vice-President.....Cannon, T. C.  
 Secy.-Treas.....Kemper, H. D.

**Members**

Cannon, T. C., Jonesboro  
 Chambers, J. A. S., Inman  
 Henry, J. Z., Ellenwood  
 Kemper, H. D., Jonesboro  
 Lester, J. A., Fayetteville



Seawright, E. C., Fayetteville  
Wallis, G. W., Fayetteville

**COBB COUNTY****Officers**

President.....Perkinson, W. H.  
Vice-President.....Lindley, F. P.  
Secy.-Treas.....Fowler, R. W.  
Delegate.....Blair, L. L.

**Members**

Bagley, D. A., 796 Marietta St., Atlanta  
Bailey, E. M., Acworth  
Bannister, C. D., Blackwell  
Benson, W. E., Marietta  
Blair, L. L., Marietta  
Burtz, C. W., Acworth  
Elder, C. D., Marietta  
Ellis, J. W., Kennesaw  
Fowler, R. W., Marietta  
Garrett, L. G., Austell  
Haygood, G. H., Marietta  
Kemp, W. M., Marietta  
Lester, J. E., Kennesaw  
Lindley, F. P., Powder Springs  
Lyon, G. T., Roswell  
Nolan, C. T., Marietta  
Pace, W. T., Smyrna  
Perkinson, W. H., Marietta  
Power, I. C., Blackwell  
Powers, R. J., Roswell  
Welch, L. L., Marietta

**COFFEE COUNTY****Officers**

President.....Ricketson, G. M.  
Vice-President.....Sibbett, W. F.  
Secy.-Treas.....Clark, T. H.  
Delegate.....Smith, J. R.

**Members**

Clark, T. H., Douglas  
Coleman, A. S. M., Douglas  
Giddens, C. C., Broxton  
Hall, W. L., Nicholls  
Meeks, D. H., Nicholls  
Moorman, I. W., Douglas  
Quillian, B. O., Willacoochee  
Ricketson, G. M., Broxton  
Sibbett, W. F., Douglas  
Smith, J. R., Douglas  
Vinson, S. L., Douglas  
Whelchel, H. C., Douglas

**COLQUITT COUNTY****Officers**

President.....Summerlin, J. A.  
Vice-President.....Withers, S. M.  
Secy.-Treas.....Stuart, M. H.  
Delegate.....Summerlin, J. A.

**Members**

Brannen, C. C., Moultrie  
Covington, J. F., Moultrie  
Edmondson, H. T., Moultrie  
Folsom, G. H., Ellenton  
Lawson, E. L., Moultrie  
Slocumb, C. B., Doerun  
Stuart, M. H., St. Petersburg, Fla.  
Summerlin, J. A., Pelham  
Whittendale, W. H., Norman Park  
Withers, S. M., Moultrie

**COOK COUNTY****Officers**

President.....Clements, H. W.  
Vice-President.....Shepard, W. M.  
Secy.-Treas.....Hutchinson, L. R.  
Delegate.....Etridge, S. G.

**Members**

Askew, P. H., Nashville  
Clements, H. W., Adel  
Etridge, S. G., Sparks  
Hutchinson, L. R., Little River, Fla.  
Shepard, W. M., Adel

**COWETA COUNTY****Members**

Bailey, T. S., Newnan  
Barge, A. A., Newnan  
Post, W. A., Grantville  
Tribble, J. M., Senola

**CRISP COUNTY****Officers**

President.....Bradley, T. E.  
Vice-President.....Whelchel, A. J.  
Secy.-Treas.....Daniel, Byron  
Delegate.....Whelchel, A. J.

**Members**

Bradley, T. E., Cordele  
Daniel, B., Cordele  
Dorminy, J. N., Cordele  
Flournoy, H. C., Warwick  
Harvard, V. O., Arabi  
Heyward, A. R., Warwick  
Marshall, W. B., Cordele (Hon.)  
Miller, W. A., Arabi  
McArthur, T. J., Cordele  
Smith, M. R., Cordele  
Wallace, F. R., Cordele (Hon.)  
Ward, J. A., Cordele  
Ware, Ford, Americus  
Whelchel, A. J., Cordele  
Williams, H. J., Cordele  
Williams, L. E., Cordele  
Williams, P. L., Cordele  
Williams, S. F., Cordele

**DECATUR-SEMINOLE COUNTIES****Officers**

President.....Christiphine, S. A. V.  
Vice-President.....Wilkinson, W. L.  
Secy.-Treas.....Willis, L. W.  
Delegate.....Wheat, R. F.

**Members**

Alford, A. E. B., Bainbridge  
Bridges, R. L. Z., Brinson  
Brinson, H. H., Brinson  
Chason, Gordon, Bainbridge  
Chason, Thos., Donaldsonville  
Christiphine, S. A. V., Attapulgus  
Clark, Geo. T., Bainbridge  
Ehrlich, M. A., Bainbridge  
Ehrlich, Sigo, Bainbridge  
Fort, M. A., Bainbridge  
Sibbett, W. A., Bainbridge  
Sponner, J. I., Donaldsonville  
Wheat, R. F., Bainbridge  
Wilkinson, W. L., Bainbridge  
Willis, L. W., Bainbridge

**DeKALB COUNTY****Officers**

President.....Sweet, Mary F.  
Vice-President.....Daniel, J. C.  
Secy.-Treas.....Pitman, J. F.  
Delegate.....Patillo, C. E.

**Members**

Allgood, C. L., Scottdale  
Andrews, W. W., Tucker  
Ansley, W. S., Decatur  
Daniel, J. C., Decatur  
Harrison, W. A., Decatur  
Patillo, C. E., Decatur  
Pitman, J. F., Decatur  
Pounds, J. E., Ingleside  
Sweet, Mary F., Decatur  
Watkins, A. R., Chamblee  
Wilson, B. V., Decatur

**DOOLY COUNTY****Officers**

President.....Pate, R. H.  
Vice-President.....Lee, J. L.  
Secy.-Treas.....Williams, F. E.

**Members**

Bishop, L. H., Unadilla  
Bivins, T. F., Vienna  
Daves, P. C., Vienna  
Davis, E. B., Byromville  
Edenfield, W. N., Vienna  
Lee, J. L., Pinehurst  
Mobley, H. A., Vienna  
Moye, T. R., Vienna  
Pate, R. H., Unadilla  
Rose, J. R., Unadilla  
Williams, F. E., Vienna

**DOUGHERTY COUNTY****Officers**

President.....Irvin, I. W.  
Vice-President.....Welch, L. E.  
Secy.-Treas.....Redfearn, J. A.  
Delegate.....Davis, W. L.

**Members**

Bacon, A. S., Albany  
Barnett, J. M., Albany

Benson, N. E., Albany  
Cook, W. S., Albany  
Davis, W. L., Albany  
Hillsman, A. H., Albany  
Irvin, I. W., Albany  
Keaton, J. C., Albany  
McDowell, T. C., Acree  
Newell, C. E., Albany  
Redfearn, J. A., Albany  
Robinson, Hugo, Albany  
Sapp, E. F., Albany  
Welch, L. E., Albany  
Wood, A. W., Miami, Fla.

**DOUGLAS COUNTY****Officers**

President.....Vansant, C. V.  
Vice-President.....Reid, W. H.  
Secy.-Treas.....Houseworth, D.

**Members**

Hamilton, R. E., Douglasville  
Houseworth, D., Douglasville  
Reid, W. H., Douglasville  
Vansant, C. V., Douglasville

**ELBERT COUNTY****Officers**

President.....Bailey, D. V.  
Vice-President.....Johnson, A. S.  
Secy.-Treas.....Hudgens, J. C.  
Delegate.....Smith, A. C.

**Members**

Adams, F. L., Elberton, R. F. D.  
Bailey, D. V., Elberton  
Eberhardt, J. P., Elberton  
Gaines, T. H., Elberton, R. F. D.  
Hudgens, J. C., Elberton  
Johnson, A. S., Elberton  
Johnson, J. E., Elberton  
Johnson, W. A., Bowman  
Smith, A. C., Elberton  
Stovall, A. S. J., Elberton  
Thompson, D. N., Elberton  
Walker, O. B., Bowman  
Ward, G. A., Elberton, R. F. D.

**EMANUEL COUNTY****Officers**

President.....Bailey, J. D.  
Vice-President.....Nunez, J. M.  
Secy.-Treas.....Youmans, S. S.  
Delegate.....Coleman, E. T.

**Members**

Bailey, J. D., Summertown  
Chandler, J. H., Swainsboro  
Coleman, E. T., Graymont (Hon.)  
Franklin, R. C., Swainsboro  
Franklin, V. E., Graymont  
Johnson, A. C., Garfield  
Johnson, B. F., Garfield  
Lucas, W. H., Stillmore  
Nunez, J. M., Swainsboro (Hon.)  
Sample, R. L., Summit  
Smith, D. D., Swainsboro  
Smith, G. L., Swainsboro  
Youmans, S. S., Oak Park

**EVANS COUNTY****Officers**

President.....Miller, B. E.  
Secy.-Treas.....Clanton, D. S.

**Members**

Clanton, D. S., Hagan  
Daniel, B. E., Claxton  
Daniel, J. W., Claxton  
Elarbee, G. W., Daisy  
Ellis, S. T., Hagan  
Miller, B. E., Claxton

**FLOYD COUNTY****Officers**

President.....Simmons, R. O.  
Vice-President.....Routledge, A. F.  
Secy.-Treas.....Mull, J. H.  
Delegate.....Moore, Cliff

**Members**

Ballenger, J. P., Armuchee  
Battey, H. H., Rome (Hon.)  
Chandler, J. L., Rome  
Cheney, J. N., Silver Creek  
Cox, R. P., Rome  
Dellinger, A. H., Rome  
Elmore, B. V., Rome  
Floyd, W. B., Rome  
Garrard, J. L., Rome  
Harbin, R. M., Rome  
Harbin, W. P., Rome  
Lewis, W. H., Rome



Maddox, R. C., Rome  
 Methvin, S. R., Lindale  
 Moore, Clifford, Lindale  
 Mull, J. H., Rome  
 McArthur, C. H., Rome  
 McCall, J. T., Rome  
 McCord, M. M., Rome  
 McKinney, W. T., Cave Springs  
 Penn, B. W., Rome, R.F.D. No. 2  
 Routledge, A. F., Rome  
 Shamblin, A. C., Rome  
 Shaw, W. J., Rome  
 Simmons, R. O., Rome  
 Smith, G. B., Rome  
 Turner, H. A., Rome  
 Watts, J. C., Rome  
 Wicker, R. H., Rome

#### FORSYTH COUNTY

##### Officers

President.....Lipscomb, W. E.  
 Secy.-Treas.....Mashburn, M.

##### Members

Bramblett, R. H., Cumming  
 Brice, G. P., Flowery Branch  
 Lipscomb, W. E., Cumming  
 Mashburn, Marcus, Cumming  
 Ottwell, James A., Cumming  
 Pirkle, W. W., Cumming  
 Tribble, P. W., Cumming

#### FRANKLIN COUNTY

##### Officers

President.....Brown, S. D.  
 Vice-President.....Heller, W. B.  
 Secy.-Treas.....Smith, B. T.  
 Delegate.....McCrary, J. O.

##### Members

Brown, S. D., Royston  
 Cornog, W. W., Lavonia  
 Freeman, J. M., Lavonia  
 Heller, W. B., Lavonia  
 Lord, C. B., Ashland, R. F. D.  
 McCrary, H. L., Royston  
 McCrary, J. O., Royston  
 Parker, G. M., Carnesville  
 Pool, E. T., Carnesville  
 Ridgeway, G. T., Royston  
 Smith, B. T., Carnesville  
 Terrell, J. H., Jr., Lavonia  
 Williams, N. G., Canon

#### FULTON COUNTY

##### Officers

President.....Toepel, Theo.  
 Vice-President.....Campbell, J. L.  
 Secy.-Treas.....Clay, Grady E.  
 Delegate.....Davison, T. C.  
 Delegate.....Waits, C. E.  
 Delegate.....Person, W. E.  
 Delegate.....Selman, W. A.  
 Delegate.....Wagnon, B. H.  
 Delegate.....Strickler, C. W.

##### Members

Abercrombie, T. F., State Capitol, Atlanta  
 Adair, Robin, Atl. Nat. Bk. Bldg., Atlanta  
 Adams, C. R., 136 Gordon St., Atlanta  
 Adams, G. B., Emory University (Hon.)  
 Adams, H. M. S., Candler Bldg., Atlanta  
 Adkins, W. N., 79 Forrest Ave., Atlanta  
 Aiken, W. S., Hurt Bldg., Atlanta  
 Allen, E. A., Atl. Nat. Bk. Bldg., Atlanta  
 Almand, C. A., 79 Forrest Ave., Atlanta  
 Anderson, W. W., Doctors' Bldg., Atlanta  
 Armstrong, T. B., Hurt Bldg., Atlanta  
 Arnold, W. A., Atl. Nat. Bk. Bldg., Atlanta  
 Arthur, J. F., 686 Piedmont Ave., Atlanta  
 Askew, H. H., Candler Bldg., Atlanta  
 Atkins, F. M., 53 Forrest Ave., Atlanta  
 Avary, A., 97 Oakdale Drive, Atlanta (Hon.)  
 Avary, J. C., 543 W. Peachtree St., Atlanta (Hon.)  
 Aven, C. C., Atl. Nat. Bk. Bldg., Atlanta

Aycock, Mell, 54 4Forrest Ave., Atlanta  
 Ayer, G. D., Hurt Bldg., Atlanta  
 Ayers, A. J., 146 Greenwood Place, Decatur  
 Bachman, Geo., Emory University (Hon.)  
 Baggett, L. G., Hurt Bldg., Atlanta  
 Baird, J. B., Jr., Peters Bldg., Atlanta  
 Baird, N. W., 211½ Lee St., Atlanta  
 Baker, W. Pope, 79 Forrest Ave., Atlanta  
 Ballenger, E. G., Healey Bldg., Atlanta  
 Ballenger, W. L., Doctors' Bldg., Atlanta  
 Barber, W. E., Healey Bldg., Atlanta  
 Barfield, F. M., Healey Bldg., Atlanta  
 Barfield, J. R., Doctors' Bldg., Atlanta  
 Barker, N. L., Doctors' Bldg., Atlanta  
 Barnett, S. T., 20 E. Linden, Atlanta  
 Bartholomew, R. A., 20 Ponce de Leon Ave., Atlanta  
 Bealer, F. R., Federal Bldg., Atlanta (Hon.)  
 Beasley, B. T., Hurt Bldg., Atlanta  
 Benson, C. F., 4th Nat. Bk. Bldg., Atlanta (Deceased)  
 Benson, M. T., Atl. Nat. Bk. Bldg., Atlanta  
 Best, P. W., Candler Bldg., Atlanta  
 Bible, Chas. G., Hurt Bldg., Atlanta  
 Bishop, E. L., Grady Hospital, Atlanta  
 Bivings, Chas., Exchange Bldg., Atlanta  
 Bivings, F. C., Exchange Bldg., Atlanta  
 Bivings, F. L., Tr. Co. of Ga. Bldg., Atlanta  
 Bivings, W. T., Exchange Bldg., Atlanta  
 Blackburn, J. D., Atl. Nat. Bk. Bldg., Atlanta  
 Blackman, W. W., 172 Capitol Ave., Atlanta  
 Blalock, J. C., Atl. Nat. Bk. Bldg., Atlanta  
 Blandford, W. C., Candler Bldg., Atlanta  
 Blincoc, Homer, Emory University  
 Block, E. B., Doctors' Bldg., Atlanta  
 Boland, Chas. G., Haas-Howell Bldg., Atlanta  
 Boland, F. K., Doctors' Bldg., Atlanta  
 Bowcock, H. M., Doctors' Bldg., Atlanta  
 Boyd, M. L., Hurt Bldg., Atlanta  
 Boynton, C. E., 48 Forrest Ave., Atlanta  
 Brannen, Cliff, Hurt Bldg., Atlanta  
 Brawner, A. F., 79 Forrest Ave., Atlanta  
 Brawner, J. N., 79 Forrest Ave., Atlanta  
 Brice, J. Theo., 826 Peachtree St., Atlanta  
 Brown, S. T., Atl. Nat. Bk. Bldg., Atlanta  
 Brown, W. T., 33 E. Ga. Ave., Atlanta (Hon.)  
 Bucknell, Howard, 41 Forrest Ave., Atlanta  
 Buff, J. H., Hurt Bldg., Atlanta  
 Bunce, A. H., 65 Forrest Ave., Atlanta  
 Bush, O. B., Atl. Nat. Bk. Bldg., Atlanta  
 Byrd, E. S., 20 E. Linden, Atlanta  
 Byrd, H. O., Byrd-Ethridge Bldg., Atlanta  
 Caldwell, A. F., Grant Bldg., Atlanta  
 Calhoun, F. P., Doctors' Bldg., Atlanta  
 Callaway, J. T., Hurt Bldg., Atlanta

Campbell, J. L., Doctors' Bldg., Atlanta  
 Campbell, M. G., 354 Ponce de Leon Ave., Atlanta  
 Campbell, W. E., Jr., Atl. Nat. Bk. Bldg., Atlanta  
 Campbell, W. E., Sr., Atl. Nat. Bk. Bldg., Atlanta  
 Carter, H. G., Candler Bldg., Atlanta  
 Catron, I. T., 4th Nat. Bk. Bldg., Atlanta  
 Champion, W. L., Grant Bldg., Atlanta  
 Cheney, G. W. H., 746 Peachtree St., Atlanta  
 Childs, J. R., Hurt Bldg., Atlanta  
 Childs, L. W., Grant Bldg., Atlanta  
 Clark, J. J., Doctors' Bldg., Atlanta  
 Clay, Grady E., Doctors' Bldg., Atlanta  
 Clifton, B. H., Hurt Bldg., Atlanta  
 Cline, B. McH., Candler Bldg., Atlanta  
 Cofer, O. S., Grant Bldg., Atlanta  
 Cole, G. C., 907 Marietta St., Atlanta  
 Collier, T. J., 1527 Peachtree St., Atlanta  
 Colvin, E. S., Healey Bldg., Atlanta  
 Combs, J. A., Atl. Nat. Bk. Bldg., Atlanta  
 Cook, G. L., Tampa, Fla.  
 Cooper, J. H., St. Petersburg, Fla.  
 Copeloff, M. B., Grant Bldg., Atlanta  
 Corley, F. L., Atl. Nat. Bk. Bldg., Atlanta  
 Cousins, W. L., Candler Bldg., Atlanta  
 Cowan, Z. S., Candler Bldg., Atlanta  
 Crawford, E. D., Grant Bldg., Atlanta  
 Crawford, H. C., Doctors' Bldg., Atlanta  
 Crawford, J. H., Grant Bldg., Atlanta  
 Crichton, R. B., Columbus  
 Cromer, J. D., 65 Forrest Ave., Atlanta  
 Crowe, W. A., Smyrna (Hon.)  
 Curtis, C. M., College Park  
 Dabney, W. C., 95 Forrest Ave., Atlanta  
 Daly, Leo. P., 41 Forrest Ave., Atlanta  
 Daly, R. R., Ga. Sav. Bk. Bldg., Atlanta  
 Daniel, Eugene L., Kirkwood  
 Davenport, T. F., 20 Ponce de Leon Ave., Atlanta  
 Davis, E. C., 25 East Linden, Atlanta (Hon.)  
 Davis, J. E., Atl. Nat. Bk. Bldg., Atlanta  
 Davis, W. A., State Capitol, Atlanta (Hon.)  
 Davison, Hal M., Doctors' Bldg., Atlanta  
 Davison, T. C., Doctors' Bldg., Atlanta  
 Dawson, A., 357 Peters St., Atlanta  
 DeLoach, A. G., Atl. Trust Co. Bldg., Atlanta  
 Denton, J. F., Doctors' Bldg., Atlanta  
 Derr, J. S., Hurt Bldg., Atlanta  
 Dickson, Roger W., 23 E. Kimball St., Atlanta  
 Dimmock, A. M., Hurt Bldg., Atlanta  
 Donaldson, H. R., Grant Bldg., Atlanta  
 Dorrough, W. S., Doctors' Bldg., Atlanta  
 Dorsey, R. T., 20 E. Linden, Atlanta  
 Dowman, C. E., 78 Forrest Ave., Atlanta  
 Duncan, B. C., Candler Bldg., Atlanta  
 Duncan, John B., 4th Nat. Bk. Bldg., Atlanta  
 Dunn, W. M., Candler Bldg., Atlanta

- Duvall, W. B., 20 E. Linden Ave., Atlanta
- Earnest, J. G., 165 Juniper St., Atlanta (Hon.)
- Edgerton, M. T., Candler Bldg., Atlanta
- Elder, E. B., Ga. Baptist Hosp., Atlanta
- Elder, O. F., Healey Bldg., Atlanta
- Elkin, Arch, Doctors' Bldg., Atlanta
- Elkin, Dan C., 436 Peachtree St., Atlanta
- Elkin, W. S., Doctors' Bldg., Atlanta (Hon.)
- Ellis, J. N., Atl. Nat. Bk. Bldg., Atlanta
- Emery, W. B., Candler Bldg., Atlanta
- Equen, M. S., Grand Bldg., Atlanta
- Eskridge, Frank, 350 W. Peachtree St., Atlanta
- Estes, H. G., Atl. Nat. Bk. Bldg., Atlanta
- Estes, J. L., Tampa, Fla.
- Etheridge, W. M., Peters Bldg., Atlanta
- Fancher, J. K., 20 E. Linden St., Atlanta
- Fanning, O. O., Grand Bldg., Atlanta
- Fincher, E. F., 861 Flat Shoals Ave., Atlanta
- Fischer, L. C., 25 E. Linden, Atlanta
- Fitts, John B., Atl. Nat. Bk. Bldg., Atlanta
- Flick, W. A., Candler Bldg., Atlanta
- Flowers, A. P., Candler Bldg., Atlanta
- Floyd, Earl H., Hurt Bldg., Atlanta
- Floyd, J. T., 41 Forrest Ave., Atlanta
- Fort, A. G., Miami, Fla.
- Foster, K. E., College Park
- Fowler, F. M., Grant Bldg., Atlanta
- Freeman, J. F., 304 Hemphill Ave., Atlanta
- Freeman, Wm. T., Asheville, N. C.
- Fuller, G. W., Hurt Bldg., Atlanta
- Fuller, J. R., Atl. Trust Co. Bldg., Atlanta
- Funke, John, Hurt Bldg., Atlanta
- Funkhouser, W. L., 23 Kimball, Atlanta
- Gaines, L. M., 65 Forrest Ave., Atlanta
- Gardner, W. A., 79 Forrest Ave., Atlanta
- Garner, J. R., 120 E. Hunter St., Atlanta
- Gay, B. B., Candler Bldg., Atlanta
- Giddings, C. G., Doctors' Bldg., Atlanta (Hon.)
- Giddings, Glennville, Doctors' Bldg., Atlanta
- Gilbert, W. L., Atl. Nat. Bk. Bldg., Atlanta
- Gober, W. Mayes, 436 Peachtree St., Atlanta
- Goldsmith, L. H., 41 Forrest Ave., Atlanta
- Goldsmith, W. S., Healey Bldg., Atlanta (Hon.)
- Goodpasture, W. C., Hurt Bldg., Atlanta
- Goodwyn, T. P., 436 Peachtree St., Atlanta
- Greene, E. H., Doctors' Bldg., Atlanta
- Grove, L. W., 53 Forrest Ave., Atlanta
- Guffin, T. F., East Point
- Hailey, W. H., Candler Bldg., Atlanta
- Hall, C. E., 4th Nat. Bk. Bldg., Atlanta
- Hall, O. D., Hurt Bldg., Atlanta
- Hames, F. W., Candler Bldg., Atlanta
- Hancock, Chas. R., 30 Crew St., Atlanta
- Hancock, T. H., 30 Crew St., Atlanta
- Hardin, L. S., 41 Forrest Ave., Atlanta
- Harris, H. F., Wesley Rd., Atlanta
- Harrison, M. T., 25 E. Linden St., Atlanta
- Heyser, D. T., 70 S. Boulevard, Atlanta
- Highsmith, E. D., Trust Co. of Ga. Bldg., Atlanta
- Hines, J. H., 41 Forrest Ave., Atlanta
- Hinkle, F. W., Atl. Nat. Bk. Bldg., Atlanta
- Hodges, J. H., Hapeville
- Hodges, W. A., 80 Page Ave., Atlanta
- Hodgson, F. G., 746 Peachtree St., Atlanta
- Hoke, Michael, 15 W. Alexander St., Atlanta
- Holmes, C. H., 41 Forrest Ave., Atlanta
- Holmes, W. R., Doctors' Bldg., Atlanta
- Holtz, Louis, Hurt Bldg., Atlanta
- Hoppe, L. D., 79 Forrest Ave., Atlanta
- Horton, B. E., Atl. Nat. Bk. Bldg., Atlanta
- Howard, P. M., College Park
- Hudson, P. L., Atl. Nat. Bk. Bldg., Atlanta
- Huguley, G. P., 54 Forrest Ave., Atlanta
- Hull, M. McH., Grant Bldg., Atlanta
- Hunter, C. W., 350 W. Peachtree St., Atlanta
- Hurt, J. S., Doctors' Bldg., Atlanta
- Jackson, Zach W., 436 Peachtree St., Atlanta
- Jenkins, M. K., Atl. Nat. Bk. Bldg., Atlanta
- Johnson, J. C., Doctors' Bldg., Atlanta
- Johnson, Trimble, Doctors' Bldg., Atlanta
- Johnston, J. Allen, Ft. Lauderdale, Fla.
- Jones, Francis G., Asheville, N. C. (Hon.)
- Jones, Jack W., Atl. Nat. Bk. Bldg., Atlanta
- Jones, Willis B., Atl. Nat. Bk. Bldg., Atlanta
- Jones, W. T., 41 Forrest Ave., Atlanta
- Kea, V. E., Candler Bldg., Atlanta
- Kelley, L. H., Hurt Bldg., Atlanta
- Kennedy, J. P., City Hall, Atlanta
- Key, Claude T., 436 Peachtree St., Atlanta
- Kinard, J. O., Candler Bldg., Atlanta
- King, J. C., Peachtree Bldg., Atlanta
- Kirkland, S. A., 436 Peachtree St., Atlanta
- Kite, J. H., Scottish Rite Hosp., Decatur (Hon.)
- Klugh, Geo. F., 65 Forrest Ave., Atlanta
- Knight, J. H., Eagan (Hon.)
- Kraft, H. N., Candler Bldg., Atlanta
- Lake, Wm. F., 25 E. Linden, Atlanta
- Landham, J. W., 65 Forrest Ave., Atlanta
- Lawrence, C. E., Hurt Bldg., Atlanta
- Lineback, P. E., Emory University (Hon.)
- Lokey, H. M., Doctors' Bldg., Atlanta
- Longino, D. R., Atl. Nat. Bk. Bldg., Atlanta
- Longino, T. D., 61 Park St., Atlanta (Hon.)
- Lyle, W. C., Candler Bldg., Atlanta
- Lyon, H. P., 745 Marietta St., Atlanta
- Manget, J. D., 65 Forrest Ave., Atlanta
- Martin, J. J., Doctors' Bldg., Atlanta
- Mashburn, C. M., 65 Forrest Ave., Atlanta
- Matthews, O. H., 65 Forrest Ave., Atlanta
- Miller, H. C., Hurt Bldg., Atlanta
- Minor, H. W., Atl. Nat. Bk. Bldg., Atlanta
- Mizell, G. C., 54 Forrest Ave., Atlanta
- Monfort, J. M., Hurt Bldg., Atlanta
- Moon, P. L., Atl. Nat. Bk. Bldg., Atlanta
- Morris, S. L., Jr., Grant Bldg., Atlanta
- Murphy, C. E., Trust Co. Ga. Bldg., Atlanta (Hon.)
- Murray, G. M., Atl. Nat. Bk. Bldg., Atlanta
- Muse, L. H., 4th Nat. Bk. Bldg., Atlanta
- McAiley, R. Geo., 20 Ponce de Leon Ave., Atlanta
- McAllister, J. A., Hurt Bldg., Atlanta
- McCay, C. G., Atl. Nat. Bk. Bldg., Atlanta
- McCord, J. R., 61 Forrest Ave., Atlanta
- McDougall, J. C., Atl. Trust Co. Bldg., Atlanta
- McDougall, W. L., Atl. Nat. Bk. Bldg., Atlanta
- McDuffie, H. F., Hurt Bldg., Atlanta
- McGarity, J. A., 20 Ponce de Leon Ave., Atlanta
- McGee, H. M., Hurt Bldg., Atlanta
- McLarty, M. W., Atl. Nat. Bk. Bldg., Atlanta
- McRae, F. W., Jr., Doctors' Bldg., Atlanta
- McRae, J. C., Doctors' Bldg., Atlanta
- Nellans, C. T., 65 Forrest Ave., Atlanta
- Nesbit, F. C., Candler Bldg., Atlanta
- Newberry, R. E., Candler Bldg., Atlanta
- Nicolson, W. P., Jr., Doctors' Bldg., Atlanta
- Nicolson, W. P., Sr., Doctors' Bldg., Atlanta
- Niles, G. M., Candler Bldg., Atlanta
- Noble, G. H., Jr., 186 S. Pryor St., Atlanta
- Noble, G. H., Sr., 186 S. Pryor St., Atlanta
- Nunnally, H. B., Hurt Bldg., Atlanta
- Olds, B. A., East Point
- Oppenheimer, R. H., Wesley Memorial Hosp., Atlanta (Hon.)
- Owens, W. Duncan, Doctors' Bldg., Atlanta
- Owensby, N. M., Atl. Nat. Bk. Bldg., Atlanta
- Paine, C. H., 53 Forrest Ave., Atlanta
- Paullin, J. E., Doctors' Bldg., Atlanta
- Pentecost, M. P., 4th Nat. Bk. Bldg., Atlanta
- Person, W. E., Candler Bldg., Atlanta
- Petway, T. F., Atl. Nat. Bk. Bldg., Atlanta
- Pinson, C. H., Hapeville, Ga.
- Powell, J. H., Atl. Nat. Bk. Bldg., Atlanta
- Pruitt, M. C., Wynne-Claughton Bldg., Atlanta
- Quillian, G. W., 632 Peachtree St., Atlanta
- Quillian, W. E., Atl. Nat. Bk. Bldg., Atlanta
- Ragan, W. E., Jr., 79 Forrest Ave., Atlanta
- Ratliffe, J. W., Candler Bldg., Atlanta
- Rawiszer, Hubert, Candler Annex, Atlanta
- Redd, S. C., 79 Forrest Ave., Atlanta
- Reed, Clinton, Candler Bldg., Atlanta
- Reynolds, H. L., 53 Forrest Ave., Atlanta



Ridley, H. W., Haas-Howell Bldg., Atlanta  
 Rhodes, C. A., Atl. Nat. Bk. Bldg., Atlanta  
 Ridley, R. B., Jr., Atl. Nat. Bk. Bldg., Atlanta  
 Riley, J. G., Grant Bldg., Atlanta  
 Roberts, C. W., 20 E. Linden, Atlanta  
 Roberts, J. W., Doctors' Bldg., Atlanta  
 Roberts, M. H., 20 Ponce de Leon Ave., Atlanta  
 Roberts, S. R., 20 Ponce de Leon Ave., Atlanta  
 Robinson, L. B., 20 E. Linden Ave., Atlanta  
 Robinson, W. C., Atl. Nat. Bk. Bldg., Atlanta (Hon.)  
 Rosenberg, H. J., Hurt Bldg., Atlanta  
 Rouglin, L. C., Hurt Bldg., Atlanta  
 Roy, Dunbar, Grand Bldg., Atlanta  
 Rushin, C. E., Doctors' Bldg., Atlanta  
 Sage, D. Y., Ga. Sav. Bk. Bldg., Atlanta  
 Sanders, A. S., 65 Forrest Ave., Atlanta  
 Sauls, H. C., Doctors' Bldg., Atlanta  
 Sawyer, Annie L., Grant Bldg., Atlanta  
 Schneider, J. F., Decatur (East Lake)  
 Selman, W. A., 79 Forrest Ave., Atlanta  
 Shackelford, B. L., 79 Forrest Ave., Atlanta  
 Shallenberger, W. F., 23 E. Kimball St., Atlanta  
 Shanks, E. D., Doctors' Bldg., Atlanta  
 Sims, M. R., 79 Forrest Ave., Atlanta  
 Sinkoe, S. J., Candler Bldg., Atlanta  
 Smith, Archibald, Ga. Sav. Bk. Bldg., Atlanta  
 Smith, J. R., Miami, Fla.  
 Smith, Linton, 65 N. Mayson Ave., Atlanta  
 Smith, M. F., 246½ Bellwood Ave., Atlanta  
 Smith, W. R., 746 Peachtree St., Atlanta  
 Sommerfield, J. E., Healey Bldg., Atlanta  
 Spearman, G. F., 41 Forrest Ave., Atlanta  
 Spears, Thos. A., Tr. Co. of Ga. Bldg., Atlanta  
 Stampa, S., Candler Bldg., Atlanta  
 Steedly, B. B., Spartanburg, S. C.  
 Stegall, Paul, 237 N. Jackson Atlanta  
 Steinberg, Miguel, Battle Hill Sanitarium, Atlanta (Hon.)  
 Stephens, L. P., Grant Bldg., Atlanta (Deceased)  
 Stephens, R. G., Candler Bldg., Atlanta  
 Stillman, W. K., 54 Juniper St., Atlanta  
 Stirling, A. W., Atl. Trust Co. Bldg., Atlanta  
 Stockard, C., Doctors' Bldg., Atlanta  
 Strickler, C. W., 53 Forrest Ave., Atlanta  
 Sutton, F. M., 65 Forrest Ave., Atlanta  
 Swanson, Cosby, Doctors' Bldg., Atlanta  
 Thomas, E. B., Hurt Bldg., Atlanta  
 Thompson, J. D., 78 Forrest Ave., Atlanta  
 Thornton, Lawson, 15 W. Alexander St., Atlanta  
 Thrash, E. C., 79 Forrest Ave., Atlanta  
 Toepel, Theo., 65 Forrest Ave., Atlanta  
 Tribble, N. O., Atl.-Sou. Dental College, Atlanta  
 Turner, J. W., Danville, Va.  
 Upchurch, W. A., Atl. Nat. Bk. Bldg., Atlanta

Upshaw, C. B., 23 E. Kimball St., Atlanta  
 Van Dyke, A. H., Grant Bldg., Atlanta  
 Vaughn, C. J., 246 Houston St., Atlanta (Hon.)  
 Vaughn, H. J., Hurt Bldg., Atlanta  
 Vinson, C. D., 54 Anniston Ave., Atlanta  
 Vogt, F. A., Miami, Fla.  
 Wagnon, B. H., 57 E. Fair St., Atlanta (Deceased)  
 Waits, Chas. E., Hurt Bldg., Atlanta  
 Ward, Emmett, Wynne-Claughton Bldg., Atlanta  
 Ware, C. E., Hurt Bldg., Atlanta  
 Warnock, R. T., 65 Forrest Ave., Atlanta  
 Warren, W. C., Atl. Nat. Bk. Bldg., Atlanta  
 Weaver, J. C., 78 Forrest Ave., Atlanta  
 Wells, W. Frank, 65 Forrest Ave., Atlanta  
 West, C. M., Dade City, Fla.  
 West, Ingh, DeLand, Fla.  
 Westmoreland, W. F., 53 Forrest Ave., Atlanta (Hon.)  
 White, Jno. B., 65 Forrest Ave., Atlanta  
 White, J. C., Atl. Nat. Bk. Bldg., Atlanta  
 White, O. T., 372 N. Jackson St., Atlanta  
 Wiggins, L. W., Atl. Nat. Bk. Bldg., Atlanta  
 Wilkins, C. A., Hurt Bldg., Atlanta  
 Wood, James A., Doctors' Bldg., Atlanta  
 Wood, J. G., 66 E. Ellis St., Atlanta  
 Yampolsky, Jos., Candler Bldg., Atlanta  
 Yankey, W. E., Doctors' Bldg., Atlanta  
 Young, W. W., 41 Forrest Ave., Atlanta

#### GLYNN COUNTY

##### Officers

President.....Dunwody, J. A.  
 Vice-President.....Burford, R. E. L.  
 Secy.-Treas.....Harrell, J. P.  
 Delegate.....Simmons, John W.

##### Members

Akeridge, H. L., Brunswick  
 Branham, H. M., Brunswick  
 Burford, R. E. L., Brunswick  
 Cate, G. V., Brunswick  
 Dunwody, J. A., Brunswick  
 Greer, C. B., Brunswick  
 Harrell, J. P., Brunswick  
 Holton, T. J., Brunswick  
 Odum, W. M., Brunswick  
 Simmons, J. W., Brunswick

#### GORDON COUNTY

##### Officers

President.....Acree, M. A.  
 Vice-President.....Barnett, W. R.  
 Secy.-Treas.....Chastain, R. B.  
 Delegate.....Johnston, Z. V.

##### Members

Acree, M. A., R. F. D., No. 1, Calhoun  
 Bannister, W. L., Plainville  
 Barnett, W. R., Calhoun  
 Chastain, R. B., Calhoun  
 Erwin, J. M., Calhoun  
 Fite, B. W., Resaca  
 Gray, R. M., Sugar Valley  
 Johnston, Z. V., Route 1, Calhoun  
 Mills, G. W., Calhoun  
 McLain, C. F., Calhoun  
 Richards, W. R., Calhoun  
 Rogers, R. L., Fairmount

#### GRADY COUNTY

##### Officers

President.....Warnell, J. B.  
 Secy.-Treas.....Rogers, J. V.  
 Delegate.....Rogers, J. V.

##### Members

Arline, T. J., Cairo  
 Brawner, L. E., 79 Forrest Ave., Atlanta  
 Edge, H. M., Cairo

Harden, J. E., Whigham  
 Lindsay, J. A., Cairo  
 Moore, W. R., Cairo  
 Reynolds, A. B., Reno  
 Rogers, J. V., Cairo  
 Walker, W. A., Cairo  
 Warnell, J. B., Cairo

#### GREENE COUNTY

##### Officers

Secy.-Treas.....Gheesling, Goodwin

##### Members

Adams, E. G., Greensboro  
 Gheesling, Goodwin, Greensboro  
 Holcombe, T. L., Union Point  
 Lewis, W. H., Siloam

#### GWINNETT COUNTY

##### Officers

President.....Hutchins, W. J.  
 Vice-President.....Pierce, N. H.  
 Secy.-Treas.....Guthrie, N. J.  
 Delegate.....Kelley, D. C.

##### Members

Cochran, J. S., Norcross  
 Guthrie, N. J., Norcross  
 Hambrick, H. P., Buford  
 Hinton, W. T., Dacula  
 Hutchins, W. J., Buford  
 Kelley, C. A., Lilburn  
 Kelley, D. C., Lawrenceville  
 Kelley, G. S., Lawrenceville  
 Loft, W. H., Buford  
 Orr, J. C., Buford  
 Pierce, N. H., Suwanee

#### HABERSHAM COUNTY

##### Officers

President.....Chandler, W. V.  
 Vice-President.....Duckett, P. Y.  
 Secy.-Treas.....Lamb, R. B.  
 Delegate.....Harden, O. N.

##### Members

Brabson, T. H., Cornelia  
 Burns, J. K., Sr., Clarksville  
 Chandler, W. V., Baldwin  
 Collins, Katherine R., Turnerville  
 Duckett, P. Y., Cornelia  
 Garrison, W. H., Clarksville  
 Glidden, Edson W., Alto  
 Jackson, J. B., Clarksville  
 Lamb, E. H., Demorest  
 Lamb, R. B., Demorest  
 McClure, J. H., Cornelia

#### HALL COUNTY

##### Officers

President.....Rogers, R. L.  
 Vice-President.....Neal, L. G.  
 Secy.-Treas.....Cheek, Pratt  
 Delegate.....Burns, J. K., Jr.

##### Members

Blackwelder, B. D., Gainesville  
 Bryson, L. R., Gainesville  
 Burns, J. K., Jr., Gainesville  
 Butler, C. G., Gainesville  
 Cheek, Pratt, Gainesville  
 Davis, B. B., Gainesville  
 Downey, J. H., Gainesville  
 Gibbs, E. T., Gainesville  
 Gower, J. C., Gainesville  
 Mauldin, J. D., Gainesville  
 Meeks, J. L., Gainesville  
 Meeks, W. T., New Holland  
 McCurdy, E. L., Dahlonega  
 Neal, L. G., Cleveland  
 Palmour, W. A., Gainesville  
 Phillips, H. K., Helen  
 Quillian, W. H., Lula  
 Rogers, R. L., Gainesville  
 Rudolph, J. B., Gainesville  
 Simpson, J. R., Miami, Fla.  
 Titshaw, H. S., Gainesville  
 Wheelchel, C. D., Gainesville  
 Williams, Geo. C., Clermont

#### HANCOCK COUNTY

##### Members

Jernigan, C. S., Sparta

#### HARALSON COUNTY

##### Members

Malone, W. H., Tallapoosa

#### HART COUNTY

##### Officers

President.....Gaines, T. R.  
 Vice-President.....Meredith, A. O.  
 Secy.-Treas.....McCurry, W. E.  
 Delegate.....Teasley, B. C.



**Members**

Clark, Geo. S., Hartwell  
 Gaines, T. R., Hartwell  
 Hailey, W. I., Hartwell  
 Hanie, A. P., Hartwell  
 Harper, G. T., Dewy Rose  
 Jenkins, J. C., Hartwell  
 Jenkins, J. I., Bowman  
 Meredith, A. O., Hartwell  
 McCurry, W. E., Hartwell  
 Teasley, B. C., Hartwell

**HENRY COUNTY**  
**Officers**

President.....Crawford, R. L.  
 Vice-President.....Weldon, J. B.  
 Secy.-Treas.....Sloan, W. P.  
 Delegate.....Tye, R. L.

**Members**

Colvin, E. G., Locust Grove  
 Crawford, R. L., Locust Grove  
 Ellis, H. C., McDonough  
 Sloan, W. P., McDonough  
 Smith, J. G., McDonough  
 Tye, R. L., McDonough  
 Weldon, J. B., Hampton

**HOUSTON COUNTY****Members**

Cater, R. L., Perry  
 Evans, E. L., Perry  
 Evans, H. E., Perry  
 Orr, W. L., Perry  
 Story, J. W., Kathleen

**IRWIN COUNTY****Officers**

President.....Willis, G. W.  
 Vice-President.....Harper, A.  
 Secy.-Treas.....Whiddon, L. L.  
 Delegate.....Harper, A.

**Members**

Harper, A., Wray  
 Luke, J. C., Ocilla  
 McElroy, S. L., Ocilla  
 Whiddon, L. L., Ocilla  
 Willis, G. W., Ocilla

**JACKSON COUNTY****Officers**

President.....Shankle, O. E.  
 Vice-President.....Kennedy, W. C.  
 Secy.-Treas.....Bennett, J. C.  
 Delegate.....Freeman, R.

**Members**

Allen, L. C., Hoschton  
 Allen, M. B., Hoschton  
 Bennett, J. C., Jefferson  
 Campbell, J. H., Jefferson  
 Crow, H. E., Talmo  
 Freeman, Ralph, Commerce  
 Hardman, L. G., Commerce  
 Hubbard, F. M., Commerce  
 Kennedy, W. C., Talmo  
 McDonald, E. M., Jefferson  
 Rogers, A. A., Commerce  
 Shankle, O. E., Commerce  
 Sharp, L. J., Commerce  
 Smith, S. J., Jefferson

**JASPER COUNTY****Officers**

President.....Pittard, L. Y.  
 Vice-President.....Brown, J. A.  
 Secy.-Treas.....Lancaster, E. M.  
 Delegate.....Cary, R. F.

**Members**

Anderson, J. F., Hillsboro  
 Belcher, F. S., Monticello  
 Brown, J. A., Shady Dale  
 Cary, R. F., Monticello  
 Lancaster, E. M., Shady Dale  
 Pittard, L. Y., Monticello

**JENKINS COUNTY****Officers**

President.....Perkins, M. E.  
 Vice-President.....Mulkey, Q. A.  
 Secy.-Treas.....Thompson, C.  
 Delegate.....Thompson, C.

**Members**

Lee, H. G., Millen  
 Mulkey, Q. A., Millen  
 Perkins, M. E., Millen  
 Thompson, C., Millen

**JOHNSON COUNTY****Officers**

President.....Harris, T. L.  
 Vice-President.....Harrison, D. C.

Secy.-Treas.....Brantley, J. G.  
 Delegate.....Brinson, R. E.

**Members**

Brantley, J. G., Wrightsville  
 Bray, H. B., Wrightsville  
 Brinson, R. E., Wrightsville  
 Harris, T. L., Wrightsville  
 Harrison, D. C., Kite

**JONES COUNTY****Officers**

President.....Riley, J. H.  
 Secy.-Treas.....Chambliss, P. R.  
 (Deceased)  
 Delegate.....Zachary, J. D.

**Members**

Chambliss, P. R., Gray (Deceased)  
 Riley, J. H., Haddock  
 White, B. L., St. Petersburg, Fla.  
 Zachary, J. D., Gray

**LAMAR COUNTY****Officers**

President.....Suggs, C. E.  
 Vice-President.....Barron, J. M. F.  
 Secy.-Treas.....Anderson, J. M.  
 Delegate.....Willis, C. H.

**Members**

Anderson, J. M., Barnesville  
 Barron, J. M. F., R. F. D., Milner  
 Corry, J. A., Barnesville  
 Pritchett, D. W., Barnesville  
 Rogers, J. M., Barnesville  
 Suggs, C. E., Barnesville  
 Willis, C. H., Barnesville

**LAURENS COUNTY****Officers**

President.....New, J. E.  
 Secy.-Treas.....Cheek, O. H.  
 Delegate.....Claxton, E. B.

**Members**

Barton, J. J., Dublin  
 Beddingfield, W. E., Rentz  
 Brigham, W. R., Dublin  
 Chappell, R. J., Dudley  
 Cheek, O. H., Dublin  
 Claxton, E. B., Dublin  
 Coleman, A. T., Dublin  
 Edmondson, J. W., Dublin  
 Hall, T. H., Dublin (Deceased)  
 Kea, T. B., Adrian  
 Montford, H. L., Dublin  
 Murray, D. L., Dexter  
 New, J. E., Dexter  
 Thompson, W. C., Dublin  
 Walker, Sidney, Dublin  
 Weddington, J. L., North Carolina

**LOWNDES COUNTY****Officers**

President.....Little, A. G.  
 Secy.-Treas.....Thomas, J. A.  
 Delegate.....Bird, Frank

**Members**

Bird, Frank, Valdosta  
 Freeman, D. W., Valdosta  
 Griffin, A., Valdosta  
 Huey, H. G., Homerville  
 Little, A. G., Valdosta  
 Mixson, J. F., Valdosta  
 Pennington, J. W., Howell  
 Pennington, T. E., Naylor  
 Prescott, J. P., Lake Park  
 Quarterman, P. C., Valdosta  
 Smith, E. J., Hahira  
 Smith, J. M., Valdosta  
 Smith, T. H., Valdosta  
 Talbot, T. M., Valdosta (Hon.)  
 Thomas, F. H., Valdosta  
 Thomas, J. A., Valdosta  
 Weathers, A. F., Miami, Fla.

**MACON-TAYLOR COUNTIES****Officers**

President.....Greer, C. A.  
 Vice-President.....Montgomery, R. C.  
 Secy.-Treas.....Mullino, F. M.

**Members**

Bryan, S. H., Reynolds  
 Derrick, H. C., Oglethorpe  
 Flekling, C. F., Butler  
 Frederick, D. B., Marshallville  
 Greer, C. A., Oglethorpe  
 Lightner, L. L., Ideal  
 Mangham, J. E., Reynolds  
 Montgomery, R. C., Butler  
 Mullino, F. M., Montezuma  
 McGill, R. E., Montezuma

Richardson, C. H., Sr., Montezuma

**MADISON COUNTY****Officers**

President.....Hampton, H. H.  
 Secy.-Treas.....Gholston, W. D.  
 Delegate.....Roper, L. E.

**Members**

Baker, J. L., Carlton  
 Banister, H. G., Ila  
 Gholston, W. D., Danielsville  
 Hampton, H. H., Colbert  
 Hampton, O. E., Jackson, Tenn.  
 Loden, G. L., Colbert  
 Moore, M. P., Carlton  
 Roper, L. E., Hollywood, Fla.  
 Westbrook, R. J., Ila  
 Whelchel, C. C., Comer  
 Whelchel, Fred C., Comer

**MERIWETHER COUNTY****Officers**

President.....Johnson, J. A.  
 Vice-President.....Bennett, V. H.  
 Secy.-Treas.....Gilbert, R. B.  
 Delegate.....Gilbert, R. B.

**Members**

Allen, W. P., Woodbury  
 Bennett, V. H., Gay  
 Dixon, J. L., Woodbury  
 Ellis, W. P., Gay  
 Gilbert, R. B., Greenville  
 Jackson, J. L., Manchester  
 Jackson, T. W., Manchester  
 Johnson, J. A., Manchester  
 Williams, V. G., Odessadale  
 Witt, M. S., Manchester

**MITCHELL COUNTY****Officers**

President.....Cranford, O. G.  
 Secy.-Treas.....Luke, D. P.  
 Delegate.....Spence, J. M.

**Members**

Belcher, D. P., Pelham  
 Brown, J. L., Camilla  
 Clements, J. R., Pelham  
 Cranford, O. G., Sale City  
 Lewis, F. L., Camilla  
 Roles, C. L., Camilla  
 Spence, J. M., Camilla  
 Stevens, A. T., Sale City  
 Stevenson, C. A., Camilla  
 Williams, B., Pelham

**MONROE COUNTY****Officers**

President.....Smith, B. L.  
 Vice-President.....Goolsby, R. C., Jr.  
 Secy.-Treas.....Smith, W. J.  
 Delegate.....Alexander, G. L.

**Members**

Alexander, G. L., Forsyth  
 Elrod, J. O., Forsyth  
 Goolsby, R. C., Jr., Forsyth  
 Goolsby, R. C., Sr., Forsyth  
 Ponder, W. P., Forsyth  
 (Deceased)  
 Smith, B. L., Forsyth  
 Smith, W. J., Juliette

**MONTGOMERY COUNTY****Members**

Dees, J. H., Alston  
 Palmer, J. W., Ailey

**MORGAN COUNTY****Officers**

President.....Fambrough, W. M.  
 Vice-President.....McGeary, W. C.  
 Secy.-Treas.....Carter, D. M.  
 Delegate.....Porter, J. L.

**Members**

Bell, A. K., Madison  
 Carter, D. M., Madison  
 Fambrough, W. M., Bostwick  
 McGeary, W. C., Madison  
 Nicholson, J. H., Candler Bldg., Atlanta  
 Porter, J. L., Rutledge  
 Prior, F. M., Apalachee  
 Riden, C. F., Bostwick  
 Troutt, J. H., Madison (Deceased)

**MURRAY COUNTY****Officers**

President.....Bradley, R. H.  
 Vice-President.....Colvard, T. W.  
 Secy.-Treas.....Bradford, J. E.

**Members**

Bradford, J. E., Spring Place  
 Bradley, R. H., Chatsworth  
 Colvard, T. W., Crandall  
 Dickie, E. H., Chatsworth  
 Jones, F. M., Chatsworth (Hon.)

**MUSCOGEE COUNTY****Officers**

President.....Jordan, W. P.  
 Vice-President.....Wooldridge, J. C.  
 Secy.-Treas.....Blackmar, F. B.  
 Delegate.....Anderson, J. M.

**Members**

Anderson, J. M., Columbus  
 Baird, J. M., Columbus  
 Baker, E. L., Columbus  
 Blackmar, Francis B., Columbus  
 Blanchard, Mercer, Columbus  
 Brannen, O. C., Columbus  
 Brooks, H. W., Columbus  
 Campbell, W. H., Columbus  
 Carter, C. B., Columbus  
 Chambers, Gordon F., Columbus  
 Cooke, W. L., Columbus  
 Cosby, F. L., Jr., Columbus  
 DeLamar, James, Columbus  
 Dexter, C. A., Columbus  
 Dillard, G. J., Columbus  
 Dykes, A. N., Columbus  
 Gann, W. F., Columbus (Hon.)  
 Gautier, W. T., 1647 W. 11th St.,  
 Los Angeles, Calif. (Deceased)  
 Jameson, B. B., Columbus  
 Jenkins, W. F., Columbus  
 Johnson, C. D., Columbus  
 Johnson, R. F., Columbus (Hon.)  
 Jordan, W. P., Columbus  
 Matthews, J. H., Columbus  
 Mitchell, T. E., Columbus  
 Moses, Alice, Columbus  
 Murray, G. S., Columbus  
 McDuffie, J. H., Jr., Columbus  
 McDuffie, J. H., Sr., Columbus  
 Norman, Frank P., Columbus  
 Norris, J. P., Columbus

(Deceased)

Odom, Fidelia J., Columbus  
 Peacock, C. A., Columbus  
 Pennington, J. H., Columbus  
 Pennington, M. F., Columbus  
 Tatum, P. A., Columbus  
 Thrash, J. A., Columbus  
 Tillery, Bert, Columbus  
 Williams, T. G., Columbus  
 Whitehead, W. F., Columbus  
 Winn, J. H., Columbus  
 Wooldridge, J. C., Columbus  
 Youmans, J. R., Columbus  
 Young, S. E., Midland

**McDUFFIE COUNTY****Officers**

President.....Gibson, S.  
 Vice-President.....Gibson, W. A.  
 Secy.-Treas.....Colvin, F. G.

**Members**

Blanchard, P. G., Appling  
 Boland, S. A., Thomson  
 Colvin, F. G., Thomson  
 Dozier, L. L., Thomson  
 Gibson, Sterling, Thomson  
 Gibson, W. A., Thomson  
 Story, Z. M., Thomson

**NEWTON COUNTY****Officers**

Secy.-Treas.....Travis, W. D.

**Members**

Lovelace, J. C., Porterdale  
 Pharr, Lenard J., Newborn  
 Randle, J. H., Rt. 8, Covington  
 Sams, J. R., Rt. 8, Covington  
 Travis, W. D., Covington  
 Waites, S. L., Covington  
 Wilson, Pleas., Newborn

**OCMULGEE SOCIETY****Officers**

President.....Mathews, W. A.  
 Vice-President.....Coleman, W. A.  
 Secy.-Treas.....Pirkle, W. H.  
 Delegate.....Coleman, W. A.

**Members**

Brown, E. C., Hawkinsville  
 Coleman, W. A., Eastman  
 Massey, W. F., Chester  
 Mathews, J. L., Hawkinsville  
 Mathews, W. A., Hawkinsville  
 Pirkle, W. H., Cochran

Smith, A. L., Cochran  
 Smith, E. L., Eastman  
 Smith, J. M., Cochran  
 Wall, J. C., Eastman  
 Whipple, R. L., Cochran  
 Williams, W. C., Delray, Fla.

**PAULDING COUNTY****Members**

Ragsdale, Geo. W., Hiram  
 Simmons, J. L., Dallas

**PEACH COUNTY****Members**

Hickson, M. L., Fort Valley

**PICKENS COUNTY****Members**

Atherton, H. G., Jasper

**PIKE COUNTY****Officers**

Secy.-Treas.....Head, M. M.  
 Delegate.....Grubbs, J. H.

**Members**

Beauchamp, J. C., Williamson  
 (Hon.)  
 Beauchamp, W. L., Williamson  
 Graves, J. R., Zebulon  
 Grubbs, J. H., Molena  
 Head, D. L., Zebulon  
 Head, J. M., Zebulon (Hon.)  
 Head, M. E., Zebulon  
 Howard, I. B., Williamson  
 Mallory, R. A., Concord

**POLK COUNTY****Officers**

President.....Whitley, S. L.  
 Vice-President.....Peek, C. W.  
 Secy.-Treas.....Good, John W.  
 Delegate.....Richardson, E. H.

**Members**

Chandron, P. O., Cedartown  
 Cooper, J. J., Cedartown  
 England, W. G., Cedartown  
 Good, John W., Cedartown  
 Hall, H. M., Cedartown  
 Howell, J. L., Aragon  
 McBryde, T. E., Rockmart  
 Peek, C. W., Cedartown  
 Pennington, J. E., Esom Hill  
 Richardson, E. H., Cedartown  
 Whitely, S. L., Cedartown  
 Wood, C. V., Cedartown

**PUTNAM COUNTY****Officers**

President.....Taliaferro, V. H.  
 Vice-President.....Griffith, E. F.  
 Sec.-Treas.....Clark, S. A.  
 Delegate.....Taliaferro, V. H.

**Members**

Clark, S. A., Lakeland, Fla.  
 Griffith, E. F., Eatonton  
 Taliaferro, V. H., Eatonton  
 Walker, E. Y., Willard

**RANDOLPH COUNTY****Officers**

President.....Crook, W. W.  
 Vice-President.....Gary, Loren  
 Secy.-Treas.....Moore, G. Y.  
 Delegate.....Patterson, J. C.

**Members**

Binion, W. W., Benevolence (Hon.)  
 Crittenden, A. L., Shellman  
 Crook, W. W., Cuthbert  
 Gary, Loren, Georgetown  
 Harper, T. F., Coleman  
 Ingram, H. R., Coleman  
 Martin, F. M., Shellman  
 Moore, G. Y., Cuthbert  
 McCurdy, E. C., Shellman  
 Patterson, F. D., Cuthbert  
 Patterson, J. C., Cuthbert  
 Rogers, F. S., Coleman  
 Rogers, W. T., Coleman (Hon.)  
 Sauretz, Annette McD., Cuthbert  
 (Hon.)  
 Shepard, J. L., Carnegie

**RICHMOND COUNTY****Officers**

President.....Cranston, W. J.  
 Vice-President.....Bryans, C. I.  
 Secy.-Treas.....Agee, M. P.  
 Delegate.....Mulherin, W. A.

Delegate.....Davidson, A. A.

**Members**

Agee, M. P., Augusta  
 Akerman, J., Augusta  
 Armstrong, R. M., Augusta  
 Baines, M. Carroll, Augusta  
 Baker, H. J., Augusta  
 Battey, W. W., Jr., Augusta  
 Beddingfield, W. R., Augusta  
 Bernard, G. T., Augusta  
 Blanchard, C. A., Augusta  
 Bryans, C. I., Augusta  
 Bryson, R. I., Augusta  
 Burdshaw, J. F., Augusta  
 Burpee, C. M., Augusta  
 Butler, J. H., Augusta  
 Chaney, R. H., Augusta  
 Coleman, T. D., Augusta  
 Crane, C. W., Augusta  
 Cranston, W. J., Augusta  
 Davidson, A. A., Augusta  
 Eve, H. J., Augusta  
 Goodrich, W. H., Augusta  
 Gray, J. D., Augusta  
 Hankinson, S. H., Augusta  
 Harrell, H. P., Augusta  
 Harris, R. L., Augusta  
 Harrison, W. H., Jr., Augusta  
 Harvey, W. L., Bartow  
 Holmes, L. P., Augusta  
 Horne, G. T., Augusta  
 Hull, Asbury, Augusta  
 Hull, J. M., Augusta  
 Jameson, W. B., Augusta  
 Jennings, W. D., Augusta  
 Kellogg, W. C., Augusta  
 Kelly, G. Lombard, Augusta  
 Kelly, J. O., Avera  
 Kershaw, M. M., Augusta  
 Kershaw, Theo., Augusta  
 Ketchins, S. C., Louisville  
 Kilpatrick, A. J., Augusta  
 Lamar, R. V., Augusta  
 Lee, F. Lausing, Augusta  
 Lentz, C. S., Augusta  
 Levy, M. S., Augusta  
 Lewis, J. R., Louisville  
 Lewis, S. J., Augusta  
 Malone, H. H., Augusta  
 Mealings, H. G., Augusta  
 Michel, H. M., Augusta  
 Milligan, K. W., Augusta  
 Montgomery, C. J., Augusta  
 Moore, N. M., Augusta  
 Mountain, G. W., Augusta  
 Moy, E. R., Lincolnton  
 Mulherin, F. X., Augusta  
 Mulherin, W. A., Augusta  
 Murphey, E. E., Augusta  
 Neagle, H. B., Augusta  
 Neil, T. F., Augusta  
 Oertel, T. E., Augusta  
 Page, Hugh N., Augusta  
 Phinizy, Irvine, Augusta  
 Pilcher, J. J., Wrens  
 Pitcher, Geo. S., Augusta  
 Price, W. T., Augusta  
 Pund, Edgar R., Augusta  
 Revell, S. T. R., Louisville  
 Rhodes, R. L., Augusta  
 Rhodes, W. J., Louisville  
 Rice, E. P., Augusta  
 Roberts, W. H., Augusta  
 Robertson, J. R., Augusta  
 Rogers, Frank M., Augusta  
 Salley, O. B., Augusta  
 Sebnitzky, E. O., Augusta  
 Shaw, H. W., Augusta  
 Sherman, John, Augusta  
 Shuman, P. A., Blythe  
 Silver, D. M., Augusta  
 Sydenstricker, V. P., Augusta  
 Tessier, L. P., Augusta  
 Thompson, Burton H., Augusta  
 Timmons, C. C., Augusta  
 Traylor, G. A., Augusta  
 Tyler, L. V., Hephzibah  
 Wade, A. C., Augusta  
 Walton, Chas. R., Augusta  
 Walton, Geo. Roscoe, Augusta  
 Weeks, J. L., Harlem  
 Wilcox, E. A., Augusta  
 Wright, J. C., Augusta  
 Wright, Lewis H., Augusta  
 Wright, P. B., Augusta

**SCREVEN COUNTY****Officers**

President.....Lovett, W. R.  
 Secretary.....Reddick, A. B.  
 Treasurer.....Lanier, L. F.



**Members**

Brantley, T. B., Hilltonia  
 Cail, John C., Sylvania  
 Doster, H. W., Rocky Ford  
 Evans, W. W., Halcynondale  
 Ezell, H. E., Oliver  
 Lanier, L. F., Rocky Ford  
 Lewis, A. D., Sylvania  
 Lovett, W. R., Sylvania  
 Mins, S. W., Sylvania  
 Powell, J. W., Sylvania  
 Reddick, A. B., Sylvania

**SPALDING COUNTY****Officers**

President.....Hunt, K. S.  
 Vice-President.....Miles, W. C.  
 Secy.-Treas.....Hawkins, T. I.  
 Delegate.....Frye, A. H.

**Members**

Anthony, E. R., Sr., Griffin (Hon.)  
 Anthony, J. R., Griffin  
 Austin, W. H., Griffin  
 Beason, Lewis, Experiment  
 Carson, M. F., Miami, Fla.  
 Conn, Webb, Griffin  
 Drewry, T. E., Griffin  
 Forrer, D. A., Griffin  
 Frye, A. H., Griffin  
 Gable, L. M., Griffin  
 Gable, N. W., Brooks  
 Griffith, C. F., Griffin  
 Haisfield, H. B., Griffin  
 Hawkins, T. I., Griffin  
 Huckaby, A. H., Griffin  
 Hunt, K. S., Griffin  
 Miles, W. C., Griffin  
 Thomas, J. M., Griffin  
 Tucker, C. L., Griffin

**STEPHENS COUNTY****Officers**

President.....Fresh, W. M.  
 Vice-President.....Chaffin, E. F.  
 Secy.-Treas.....Ayers, C. L.  
 Delegate.....Ayers, C. L.

**Members**

Ayers, C. L., Toccoa  
 Chaffin, E. F., Toccoa  
 Craig, Alexander, Toccoa  
 Davis, Jeff, Toccoa  
 Fresh, W. M., Toccoa  
 Isbell, J. E. D., Toccoa  
 Littlejohn, W. S., Rugalo  
 McBeth, W. L., Toccoa (Deceased)  
 Parker, W. H., Toccoa  
 Swain, W. H., Martin  
 Terrell, J. H., Toccoa

**STEWART-WEBSTER COUNTIES****Officers**

President.....Lunsford, G. G.  
 Vice-President.....Foster, J. H.  
 Secy.-Treas.....Walton, M.  
 Delegate.....Kenyon, J. M.

**Members**

Allen, R. H., Omaha  
 Foster, J. H., Preston  
 Greer, R. L., Lumpkin  
 Kenyon, J. M., Richland  
 Lovvorn, R. M., Richland  
 Lunsford, G. G., Weston  
 Lynch, C. S., Lumpkin  
 Pickett, C. E., Richland  
 Sims, W. C., Richland  
 Walton, Milton, Lumpkin

**SUMTER COUNTY****Officers**

President.....Wood, Kenneth  
 Vice-President.....Simpson, H. T.  
 Secy.-Treas.....Anderson, E. B.  
 Delegate.....Smith, H. A.

**Members**

Allen, H. B., Americus (Deceased)  
 Anderson, E. B., Americus  
 Bagley, Geo. W., Jr., De Soto  
 Boggs, H. L., Cobb  
 Cato, F. L., Americus  
 Chambliss, J. W., Americus  
 Grubbs, L. F., Americus  
 Jordon, J. R., Ellaville  
 Logan, J. C., Plains  
 Lunsford, J. F., Preston  
 Payne, J. W., Miami, Fla.  
 Prather, W. S., Americus  
 Primrose, A. C., Americus

Simpson, H. T., Smithville  
 Smith, H. A., Americus  
 Stukes, J. T., Americus  
 Wise, B. J., Plains  
 Wise, B. T., Plains  
 Wise, S. P., Plains  
 Wood, Kenneth, Leslie

**TALBOT COUNTY****Officers**

Vice-President.....Peeler, J. E.  
 Secy.-Treas.....Carson, C. C.

**Members**

Carson, C. C., Talbotton  
 Douglas, W. C., Talbotton  
 Leonard, W. P., Talbotton  
 Peeler, J. E., Woodland

**TATNALL-EVANS COUNTIES****Officers**

President.....Hughes, J. M.  
 Vice-President.....Kennedy, J. J.  
 Secy.-Treas.....Smith, P. H.

**Members**

Collins, J. C., Manassas  
 Harris, J. C., Reidsville  
 Hughes, J. M., Glennville  
 Jones, R. D., Eliza  
 Kennedy, J. J., Collins (Hon.)  
 Smith, P. H., Eastville, Va.  
 Tootle, G. W., Glennville  
 Walling, C. B., Collins

**TELEFAIR COUNTY****Officers**

President.....Mann, Frank  
 Vice-President.....Powell, W. H.  
 Secy.-Treas.....Maloy, C. J.  
 Delegate.....Maloy, J. K.

**Members**

Born, W. H., McRae  
 Burch, G. A., Jacksonville  
 Council, M. D., McRae  
 Harrell, A. O., Milan  
 Jones, A. J., Jacksonville  
 Kennon, B. M., McRae  
 Lucas, I. M., Albany  
 Maloy, C. J., Helena  
 Maloy, D. W. F., Milan  
 Maloy, H. S., Milan  
 Maloy, J. K., Milan (Hon.)  
 Mann, Frank R., Lumber City  
 Napier, LeRoy, Lumber City  
 Neal, J. W., Scotland  
 Powell, W. H., Lumber City  
 Turner, O. W., Helena (Deceased)

**TERRELL COUNTY****Officers**

President.....Arnold, J. T.  
 Vice-President.....Holt, R. R.  
 Secy.-Treas.....Thomas, Logan  
 Delegate.....Kenyon, Steve P.

**Members**

Arnold, J. T., Parrot  
 Bowman, R. E., Bronwood  
 Chappell, Guy, Dawson  
 Dean, J. G., Dawson  
 Holt, R. R., Parrott  
 Kenyon, S. P., Dawson  
 Lamar, Lucius, Dawson  
 Lewis, J. H., Dawson  
 Thomas, Logan, Dawson

**THOMAS COUNTY****Officers**

President.....Cheshire, S. L.  
 Vice-President.....Jones, Henry  
 Secy.-Treas.....Wall, C. K.  
 Delegate.....Wall, C. K.

**Members**

Ainsworth, Harry, Thomasville  
 Andrews, Agnew, Thomasville  
 Austin, G. L., Pavo  
 Bevans, Jas. L., Thomasville  
 Cheshire, S. L., Thomasville  
 Chestnutt, T. H., Coolidge  
 DeLoach, A. W., Thomasville  
 Erickson, Mary J., Thomasville  
 Ferguson, C. H., Thomasville  
 Glover, G. B., Monticello, Fla.  
 (Hon.)  
 Harris, J. E., Pavo  
 Hill, Roy, Thomasville  
 Isler, J. N., Meigs

Jarrell, W. W., Thomasville  
 Jones, H., Coolidge  
 King, J. M., Metcalf  
 King, J. T., Thomasville  
 Little, A. D., Thomasville  
 Lundy, L. L., Boston  
 Moore, H. M., Thomasville  
 McLean, E. K., Thomasville  
 Palmer, J. B., Thomasville  
 Reid, Jas. W., Thomasville  
 Sanchez, S. E., Barwick  
 Vann, H. A., Boston (Hon.)  
 Wall, C. K., Thomasville  
 Watt, C. H., Thomasville  
 Winchester, Millard, Thomasville  
 Worrill, W. H., Ochlocknee

**TIFT COUNTY****Officers**

President.....Price, J. M.  
 Secy.-Treas.....Smith, W. T.  
 Delegate.....Hendricks, W. H.

**Members**

Baker, L. A., Tifton  
 Dinsmore, V. F., Tifton  
 Hendricks, W. H., Tifton  
 Julian, G. W., Tifton  
 Price, J. M., Tifton  
 Smith, W. T., Tifton

**TOOMBS COUNTY****Officers**

President.....Mercer, J. E.  
 Vice-President.....Aaron, I. E.  
 Secy.-Treas.....Odom, W. W.

**Members**

Aaron, I. E., Lyons  
 Currie, M. L., Vidalia  
 Findley, C. W., Vidalia  
 Hall, J. K., Lyons  
 Mercer, J. E., Vidalia  
 Odom, W. W., Lyons  
 Thompson, T. C., Vidalia  
 Youmans, H. D., Lyons

**TRI SOCIETY****Officers**

President.....Jenkins, C. J.  
 Vice-President.....Holland, S. P.  
 Secy.-Treas.....Sharp, C. K.  
 Delegate.....Jenkins, C. J.

**Members**

Barksdale, C. R., Blakely  
 Beard, J. S., Edison  
 Bridges, B. L., Morgan  
 Bridges, R. R., Leary  
 Calhoun, W. W., Arlington  
 Cheshire, J. L., Damascus  
 Crozier, J. H., Cedar Springs  
 (Deceased)

Fitzgerald, P. H., Blakely  
 Griffin, P. E., Edison  
 Hays, W. C., Colquitt  
 Hendry, J. H., Bainbridge  
 Holland, S. P., Blakely  
 Jenkins, C. J., Edison  
 Johnson, B. T., Edison  
 Keaton, P. H., Damascus  
 Roberts, C. A., Morgan  
 Sharp, C. K., Arlington  
 Shepard, W. O., Bluffton  
 Simmons, B. K., Blakely  
 Smith, E. C., Donaldsonville  
 Standifer, J. G., Blakely  
 Standifer, W. B., Blakely (Hon.)  
 Tatum, W. J., Ft. Gaines  
 Twitty, C. W., Elmodel  
 Tye, C. O., Edison

**TROUP COUNTY****Officers**

President.....Daniel, B. C.  
 Vice-President.....Taylor, T. W.  
 Secy.-Treas.....O'Neal, R. S.  
 Delegate.....Hammett, H. H.

**Members**

Amis, F. J., Jr., Hogansville  
 Avery, R. M., Chipley  
 Brock, B. H., Hogansville  
 Calhaway, Enoch, LaGrange  
 Clark, W. H., LaGrange  
 Daniel, B. C., Hogansville  
 Ebbert, C. A. P., Grantville  
 Gauntt, T. G., West Point  
 Grant, N. L., LaGrange  
 Hadaway, W. H., LaGrange



Hammett, H. H., LaGrange  
 Harvey, C. W., Hogansville  
 Herman, E. C., LaGrange  
 Lane, I. H., LaGrange  
 Lee, R. O., LaGrange  
 Morgan, D. E., LaGrange  
 McCall, W. R., LaGrange  
 McCulloh, H., West Point  
 McCumner, L. R., LaGrange  
 O'Neal, Rance, West Point  
 O'Neal, R. S., LaGrange  
 Park, B. R., LaGrange  
 Phillips, W. P., LaGrange  
 Poer, J. M., West Point  
 Ridley, F. M., Jr., LaGrange  
 Rutland, S. C., LaGrange  
 Rutland, W. W., LaGrange  
 Slack, H. R., LaGrange  
 Taylor, J. C., LaGrange  
 Taylor, T. W., West Point  
 Vineyard, T. L., LaGrange  
 Williams, C. O., West Point

### TREUTLIN COUNTY

#### Members

Barwick, G. M., Soperton  
 Lanier, L. J., Soperton

### TURNER COUNTY

#### Officers

President.....Belflower, H. M.  
 Vice-President.....Rogers, F. W.  
 Secy.-Treas.....Baxter, J. H.

#### Members

Baxter, J. H., Ashburn  
 Belflower, H. M., Sycamore  
 Dickson, W. J., Rebecca  
 Luke, D. P., Camilla  
 Moore, J. T., Tampa, Fla.  
 McElroy, J. W., Ashburn  
 Rogers, F. W., Ashburn  
 Rawlins, R. D., Rebecca  
 Story, W. L., Ashburn  
 Turner, W. J., Ashburn

### TWIGGS COUNTY

#### Officers

President.....Jones, T. S.  
 Secy.-Treas.....Rogers, H. A.  
 Delegate.....Jones, T. S.

#### Members

Jones, T. S., Jeffersonville  
 Rogers, H. A., Jeffersonville  
 Slappy, J. G., Jeffersonville  
 Wood, A. J., Fitzpatrick

### UPSON COUNTY

#### Officers

President.....Carter, R. L.  
 Vice-President.....Harris, C. A.  
 Secy.-Treas.....Adams, B. C.  
 Delegate.....Harris, C. A.

#### Members

Adams, B. C., Thomaston  
 Black, A. H., Thomaston  
 Barron, H. A., Thomaston  
 Carter, E. W., Thomaston  
 Carter, R. L., Thomaston  
 Harris, C. A., The Rock  
 Johnson, L. M., Yatesville  
 McKenzie, J. M., Thomaston  
 Williams, K. S., Thomaston  
 Wilson, S. H., Yatesville

### WALKER COUNTY

#### Officers

President.....Spearman, M. W.  
 Vice-President.....Hammond, D. W.  
 Secy.-Treas.....Hammond, J. H.  
 Delegate.....Underwood, J. M.

#### Members

Alsbrook, J. S., Rossville  
 Coulter, R. M., LaFayette  
 Crowder, M. M., Kensington  
 Elder, D. G., Chickamauga  
 Gardner, J. L., Sulphur Springs  
 Hale, B. C., Rossville  
 Hammond, D. W., LaFayette  
 Hammond, J. H., LaFayette  
 Hice, E. H., Rock Spring

Hunter, J. P., Kensington  
 Middleton, D. S., Rising Fawn  
 Murphy, M. W., Ringgold  
 Rogers, W. D., Pittsburg  
 Shields, H. P., Chickamauga  
 Shields, J. A., LaFayette  
 Spearman, M. W., Chickamauga  
 Underwood, J. M., LaFayette  
 Wood, J. P., Kensington

### WALTON COUNTY

#### Officers

President.....Upshaw, H. L.  
 Vice-President.....Day, J. B. H.  
 Secy.-Treas.....McClintic, J. K.  
 Delegate.....Swann, W. K.

#### Members

Aycock, T. R., Monroe  
 Day, J. B. H., Social Circle  
 Floyd, C. S., Loganville  
 McClintic, J. K., Monroe  
 Reynolds, P. T., Monroe  
 Swann, W. K., Monroe  
 Upshaw, H. L., Social Circle  
 Wallace, J. W., High Shoals  
 Wells, G. R., Monroe

### WARE COUNTY

#### Officers

President.....McCullough, K.  
 Vice-President.....Mixon, W. D.  
 Secy.-Treas.....Penland, J. E.  
 Delegate.....Reavis, W. F.

#### Members

Armistead, I. G., Townsend  
 Bagley, J. B., Waycross  
 Bradley, D. M., Waycross  
 Carswell, H. J., Waycross  
 Cooper, P. P., Zirkle  
 Davis, C. L., Patterson  
 Dorminy, A. C., Hoboken  
 Drew, C. L., Tampa, Fla.  
 Flemming, A., Folkston  
 Folks, W. M., Waycross  
 Groves, W. H., Clearwater, Fla.  
 Hafford, W. C., Waycross  
 Hawkins, L. M., Blackshear  
 Hendry, G. T., Blackshear  
 Johnson, R. L., Waycross  
 Latimer, J. H., Waycross  
 Lott, W. M., Orlando, Fla.  
 Martin, E. E., High Springs, Fla.  
 McCoy, W. R., Hurt Bldg., Atlanta  
 McCullough, K. J., Waycross  
 MacDonell, G. N., Waycross  
 Minchew, B. H., Waycross  
 Mitchell, E. B., Waycross  
 Mixson, W. D., Waycross  
 Penland, J. E., Waycross  
 Reavis, W. F., Waycross  
 Shellhouse, L. H., Willacoochee  
 Stephens, C. M., Waycross  
 Walker, J. L., Waycross (Hon.)  
 Walker, R. C., Waycross  
 Williams, W. P., Blackshear  
 Witmer, C. A., Waycross

### WARREN COUNTY

#### Officers

President.....Earl, H. L.  
 Vice-President.....Ware, F. L.  
 Secy.-Treas.....Davis, A. W.  
 Delegate.....Ricketson, F. B.

#### Members

Davis, A. W., Warrenton  
 Earl, H. L., Jewell  
 Maner, G. R., Zephyrhills, Fla.  
 Ricketson, F. B., Warrenton  
 Ware, F. L., Warrenton

### WASHINGTON COUNTY

#### Officers

President.....King, T. B.  
 Vice-President.....Joiner, B. O.  
 Secy.-Treas.....Overby, N.  
 Delegate.....Burdette, J. R.

#### Members

Burdette, J. R., Tonnille  
 Dillard, J. B., Davisboro  
 Graybill, L. A., Oconee (Deceased)

Harbin, F. P., Oconee  
 Harris, E. A., Sandersville  
 Helton, B. L., Deepstep (Hon.)  
 Joiner, B. O., Tonnille  
 King, T. Byron, Sandersville  
 Lozier, N. H., Sandersville  
 Malone, G. W., Sandersville  
 Malone, Steve B., Sandersville  
 McBride, L. O., Oconee (Hon.)  
 McMaster, D. B., Tonnille  
 Newsom, N. J., Sandersville  
 Overby, N., Sandersville  
 Peacock, E. S., Harrison  
 Rawlings, F. B., Sandersville  
 Rawlings, Wm., Sandersville  
 Rogers, O. L., Sandersville  
 Taylor, Ralph L., Davisboro  
 Vickers, T. E., Wrightsville.  
 R.F.D.

Warthen, W. B., Davisboro

### WAYNE COUNTY

#### Officers

President.....Gordon, A. J.  
 Vice-President.....Ritch, T. G.  
 Secy.-Treas.....Colvin, J. T.  
 Delegate.....Gordon, A. J.

#### Members

Colvin, J. T., Jesup  
 Gordon, A. J., Jesup  
 Lee, J. A., Screven  
 Moody, E. A., Odum  
 Ogden, D. H., Odum  
 Ogden, J. K., Odum  
 Ritch, T. G., Jesup  
 Rogers, D. J., Glennville  
 Stow, M. N., Jesup  
 Tyre, J. L., Screven

### WHITFIELD COUNTY

#### Officers

President.....Starr, Trammell  
 Vice-President.....Rollins, J. C.  
 Secy.-Treas.....Kennedy, B. L.  
 Delegate.....Rollins, J. C.

#### Members

Broadrick, G. L., Dalton  
 Erwin, H. L., Dalton  
 Greene, W. J., Ringgold  
 Kennedy, B. L., Dalton  
 McAfee, J. G., Dalton  
 Rollins, J. C., Dalton  
 Russell, W. V., Dalton  
 Shellhorse, E. O., Dalton  
 Starr, Trammell, Dalton  
 Steed, J. H., Dalton  
 Wood, W. E., Dalton

### WILKES COUNTY

#### Officers

President.....Clodfelter, T. C.  
 Vice-President.....Sale, H. M.  
 Secy.-Treas.....Wood, O. S.  
 Delegate.....Simpson, A. W.

#### Members

Casteel, Lewis R., Metasville  
 Clodfelter, Thos. C., Tignall  
 Ellis, L. M., Washington  
 Harris, H. T., Washington  
 McNeil, R. J., Tignall  
 Sale, H. M., Rayle (Hon.)  
 Sherrer, G. W., Rayle  
 Simpson, A. W., Washington  
 Simpson, R. A., Washington  
 Wills, C. E., Washington  
 Wood, O. S., Washington

### WORTH COUNTY

#### Officers

President.....Tracy, J. L.  
 Vice-President.....McCoy, H. S.  
 Secy.-Treas.....Tipton, W. C.  
 Delegate.....Tipton, W. C.

#### Members

Crumbly, J. J., Sylvester  
 Ford, E. D., Doles  
 McCoy, H. S., Doerun  
 Sessions, W. W., Summer  
 Summer, G. S., Poulan  
 Tipton, W. C., Sylvester  
 Tracy, J. L., Sylvester

THE JOURNAL  
OF THE  
MEDICAL ASSOCIATION  
OF  
GEORGIA

---

I N D E X

---

Volume XIV

---

January-December, 1925

---

ALLEN H. BUNCE, M.D.  
Editor

---

COMMITTEE ON PUBLICATION

CHAS. USHER, M.D.  
S. J. LEWIS, M.D.  
T. C. THOMPSON, M.D.

21155

APR 15 1925

MEDICAL LIBRARY

## Subject Index

A. B.

- A**
- ABDOMINAL DIAGNOSIS**  
From the general practitioner's standpoint (Wm. S. Cook), p. 233, June '25.
- ADDRESS**  
Presidential (J. O. Elrod, Pres. Med. Asso. Ga.) p. 221, June '25.  
Extracts from inaugural (Theo. Toepel, Pres. Fulton Co. Med. So.), p. 150, April '25.  
President's (A. W. Simpson, Eighth District), p. 357, Sept. '25.
- ALKALOSIS ACIDOSIS**  
Case reports (John W. Daniel), p. 404, Oct. '25.
- ANENCEPHALIC MONSTER**  
(O. R. Thompson), p. 283, July '25.
- ANESTHESIA**  
Choice of in surgical operations of the rectum (Marion C. Pruitt), p. 490, Dec. '25.
- APPENDICITIS**  
Acute (W. A. Sehnan), p. 195, May '25.  
Acute, peritonitis (general), ileo appendiceal fistula; report of a case (B. T. Bensley), p. 375, Sept. '25.
- B**
- BILIARY TRACT**  
Problems of pathology of the (Wm. Howard Lewis), p. 400, Oct. '25.
- BLADDER**  
The irritable (Wallace L. Bazemore), p. 312, Aug. '25.
- BRONCHIAL SPIROCHETOSIS**  
Report of cases (Eugene E. Murphey), p. 240, June '25.
- C**
- CALCULUS**  
Ureteral bilateral, with time check on at least one stone, (C. K. Wall), p. 69, Feb. '25.
- CHILD HEALTH DEMONSTRATION**  
The Athens (Thos. Bolling Gay), p. 448, Nov. '25.
- COLON**  
Adhesive bands of ascending, with obstructive symptoms (L. W. Grove), March '25.
- COLON LAVAGE**  
Better (W. W. Blackman), p. 452, Nov. '25.
- CYSTOGRAMS**  
Air cystograms to demonstrate prostatic enlargements which protrude into the bladder (Edgar G. Balenger, Omar F. Elder and Wm. F. Lake), p. 99, March '25.
- D**
- DIABETES**  
The treatment of (J. D. Gray), p. 133, April '25.  
The treatment of and use of insulin (Thos. E. Rogers), p. 230, June '25.
- DIABETES MELLITUS**  
The treatment of (Harold I. Reynolds), p. 187, May '25.
- DIAGNOSIS**  
Making a (R. M. Harbin), p. 267, July '25.
- DRY MILK**  
Report of 2,000 infants fed on (Mather M. McCord), p. 316, Aug. '25.
- E**
- ECLAMPSIA**  
(W. L. Mathews), p. 105, March '25.
- EYE SYMPTOMS**  
The eye symptoms of constitutional disturbances (J. R. Simpson), p. 199, May '25.
- F**
- FOCAL INFECTION**  
Below the neck (J. H. Butler), p. 276, July '25.
- FOREIGN BODIES**  
Opaque and non-opaque foreign bodies in the gastrointestinal and respiratory tracts (J. W. Landham), p. 237, June '25.
- FRATERNALISM**  
(H. J. Carswell), p. 248, June '25.
- G**
- GAS BACILLUS**  
Infection (Julian K. Quattlebaum), p. 139, April '25.
- GEORGIA DOCTORS**  
Some (B. H. Wagnon), p. 153, April '25.
- GONORRHEA**  
Plea for persistency in treatment of (W. P. Jordan), p. 110, March '25.
- H**
- HAY-FEVER**  
The diagnosis and treatment of non-seasonal (Hal M. Davison), p. 21, Jan. '25.
- HEALTH WORK**  
In Georgia (T. F. Abercrombie), p. 501, Dec. '25.
- HEART-BLOCK**  
A case of with recovery (Geo. Bachmann and Walter W. Daniel), p. 18, Jan. '25.
- HEART'S ACTION**  
The attributes of the (W. W. Jarrell), p. 227, June '25.
- HERNIA**  
Industrial (Kenneth McCullough), p. 61, Feb. '25.
- HISTORY OF MEDICINE AND SURGERY**  
A sketch of the early (J. L. Campbell), p. 271, July '25.
- I**
- INFLAMMATORY BLADDER DISEASES**  
Advances in recognition and treatment of (S. A. Kirkland), p. 64, Feb. '25.
- INTESTINAL OBSTRUCTION**  
Acute (Paul W. Best), p. 192, May '25.
- INTRACRANIAL INJURIES**  
In the new horn (C. H. Richardson, Jr.), p. 484, Dec. '25.
- M**
- MASTOID CELLS**  
Breath sounds over (John R. Lewis), p. 375, Sept. '25.
- MEDICAL ASSOCIATION OF GEORGIA**  
My ideals for the (J. O. Elrod), p. 1, Jan. '25.
- MENTAL DISEASE PROBLEM**  
Some features of the (Roger C. Swint), p. 177, May '25.
- MERCUROCHROME**  
Intravenous in treatment of acute articular rheumatism (J. F. Covington), p. 320, Aug. '25.
- METASTATIC INFECTION**  
As related to foci about the head (C. I. Bryans), p. 278, July '25.
- MYXEDEMA**  
(Henry R. Slack), p. 359, Sept. '25.
- O**
- OMENTAL GRAFTS**  
As a means of relief after liberating extensive adhesions in abdomen (E. C. Davis), p. 16, Jan. '25.
- P**
- PACHYMENINGITIS**  
External pachymeningitis simulating purulent leptomeningitis; report of a case (Wm. L. McDougall), p. 56, Feb. '25.
- PEDIATRICS**  
And the Public Health (H. B. Neagle), p. 442, Nov. '25.
- PELLAGRA**  
And its treatment (L. L. Whiddon), p. 409, Oct. '25.
- PELVIC**  
Infection in the female; review of the subject (Wm. H. Myers), p. 144, April '25.
- PLEURAL EFFUSION**  
(Champneys H. Holmes), p. 59, Feb. '25.
- PNEUMONIA**  
The treatment of (Stewart R. Roberts), p. 113, March '25.
- PRECANCEROUS DERMATOSES**  
(Jack W. Jones), p. 189, May '25.
- PREVENTIVE PEDIATRICS**  
The relation of to epilepsy (G. W. Holmes Cheney), p. 285, July '25.
- PROGRAM FOR 1925**  
A debutte (F. C. Warnshuis), p. 4, Jan. '25.
- PROSTATE**  
The neglected (Chas. Hansell Watt), p. 67, Feb. '25.  
Remarks on diseases of the (J. T. Stukes), p. 202, May '25.



- R**  
**RECTAL FEEDING**  
 (Geo. M. Niles), p. 197, May '25.
- RHEUMATISM**  
 Internal secretion in (J. B. Camp), p. 183, May '25.
- S**  
**SPECIALIST**  
 Tips for the cock-sure (Elton S. Oshorne), p. 14, Jan. '25.
- SPLenic ANEMIA**  
 (H. W. Birdsong, M. A. Hubert, G. O. Whelchel), p. 453, Nov. '25.
- STATE BOARD OF HEALTH**  
 Program of the (J. P. Bowdoin), p. 10, Jan. '25.
- STATEWIDE**  
 Health association (C. H. Richardson, Jr.), p. 7, Jan. '25.
- SYPHILIS AND ITS RELATION TO NEURO-SYPHILIS**  
 Insufficient treatment of (H. D. Allen, Jr.), p. 25, Jan. '25.
- T**  
**THYROID**  
 Surgery of the gland under local anesthetics (T. C. Davison), March '25.

- TUBERCULOSIS**  
 Childhood and its relation to the tuberculosis problem, (Edson W. Glidden), p. 245, June '25.  
 Hemorrhage in pulmonary (Champneys H. Holmes), p. 414, Oct. '25.  
 The treatment of bone and joint (Lawson Thornton), p. 89, March '25.
- U**  
**ULCER**  
 X-ray in the diagnosis of duodenal ulcer (L. P. Holmes), p. 368, Sept. '25.
- ULCERS**  
 Gastric and duodenal with the medical treatment (J. D. Gray), p. 362, Sept. '25.  
 Of the stomach and duodenum, their surgical diagnosis (Ralph H. Chaney), p. 370, Sept. '25.
- URINARY TRACT**  
 Frequently overlooked conditions of the (C. D. Whelchel), p. 53, Feb. '25.
- VEGETATIVE NERVOUS SYSTEM**  
 In health and disease (J. Calvin Weaver), p. 45, Feb. '25.

## Authors' Index

- A**  
**ABERCROMBIE, T. F.**, Atlanta  
 Health Work in Georgia, p. 501, Dec. '25.
- ALLEN, H. D., Jr.**, Milledgeville  
 Insufficient Treatment of Syphilis and its Relation to Neuro-Syphilis, p. 25, Jan. '25.
- B**  
**BACHMANN, GEORGE** (and Walter W. Daniel), Emory University  
 A Case of Heart-Block with Recovery, p. 18, Jan. '25.
- BALLENGER, EDGAR G.** (and Omar F. Elder and Wm. F. Lake), Atlanta  
 Air Cystograms to Demonstrate Prostatic Enlargements Which Protrude Into the Bladder, p. 99, March '25.
- BAZEMORE, WALLACE**, Macon  
 The Irritable Bladder, p. 312, Aug. '25.
- BEASLEY, B. T.**, Atlanta  
 Acute Appendicitis, Peritonitis (General), Ileo Appendiceal Fistula, Report of a Case, p. 375, Sept. '25.
- BEST, PAUL W.**, Atlanta  
 Acute Intestinal Obstruction, p. 192, May '25.
- BIRDSONG, H. W.** (and M. A. Hubert and G. O. Whelchel), Athens  
 Splenic Anemia, p. 453, Nov. '25.
- BLACKMAN, W. W.**, Atlanta  
 Better Colon Lavage, p. 452, Nov. '25.
- BOWDOIN, J. P.**, Adairsville  
 Program of the State Board of Health, p. 10, Jan. '25.
- BRYANS, C. I.**, Augusta  
 Metastatic Infection as Related to Foci about the Head, p. 278, July '25.
- BUTLER, J. H.**, Augusta  
 Focal Infection below the Neck, p. 276, July '25.
- C**  
**CAMP, J. B.**, Carrollton  
 Internal Secretion in Rheumatism, p. 183, May '25.
- CAMPBELL, J. L.**, Atlanta  
 A Sketch of the Early History of Medicine and Surgery, p. 271, July '25.
- CARSWELL, H. J.**, Waycross  
 Fraternalism, p. 248, June '25.
- CHANEY, RALPH H.**, Augusta  
 Ulcers of the Stomach and Duodenum, Their Surgical Diagnosis, p. 370, Sept. '25.
- CHENEY, G. W. HOLMES**, Atlanta  
 The Relation of Preventive Pediatrics to Epilepsy, p. 285, July '25.
- COOK, WILLIAM S.**, Albany  
 Abdominal Diagnosis from the General Practitioner's Standpoint, p. 233, June '25.
- COVINGTON, J. F.**, Moultrie  
 Rheumatism, p. 320, Aug. '25.
- D**  
**DANIEL, JOHN W.**, Savannah  
 Alkalosis Acidosis; Case Reports, p. 404, Oct. '25.
- DANIEL, WALTER W.** (and George Bachmann), Emory University  
 A Case of Heart-Block with Recovery, p. 18, Jan. '25.
- DAVIS, E. C.**, Atlanta  
 Omental Grafts as a Means of Relief after Liberating Extensive Adhesions in Abdomen, p. 16, Jan. '25.
- DAVISON, HAL M.**, Atlanta  
 The Diagnosis and Treatment of Non-Seasonal Hay Fever, p. 21, Jan. '25.
- DAVISON, T. C.**, Atlanta  
 Surgery of the Thyroid Gland Under Local Anesthesia, p. 91, March '25.
- E**  
**ELDER, OMAR F.** (and Edgar G. Ballenger and Wm. F. Lake), Atlanta  
 Air Cystograms to Demonstrate Prostatic Enlargements Which Protrude Into the Bladder, p. 99, March '25.
- ELROD, J. O.**, Forsyth  
 My Ideals for the Medical Association of Georgia, p. 1, Jan. '25.  
 Presidential Address (Medical Association), p. 221, June '25.
- G**  
**GAY, THOS. BOLLING**, Athens  
 The Athens Child Health Demonstration, p. 448, Nov. '25.
- GLIDDEN, EDSON W.**, Alto  
 Childhood Tuberculosis and Its Relation to the Tuberculosis Problem, p. 245, June '25.
- GRAY, J. D.**, Augusta  
 Gastric and Duodenal Ulcers with the Medical Treatment, p. 362, Sept. '25.  
 The Treatment of Diabetes, p. 133, April '25.
- GROVE, L. W.**, Atlanta  
 Adhesive Bands of Ascending Colon, with Obstructive Symptoms, p. 95, March '25.

## H

- HARBIN, R. M., Rome  
Making a Diagnosis, p. 267, July '25.
- HOLMES, CHAMPNEYS H., Atlanta  
Hemorrhage in Pulmonary Tuberculosis, p. 414, Oct. '25.  
Pleural Effusion, p. 59, Feb. '25.
- HOLMES, L. P., Augusta  
X-Ray in the Diagnosis of Duodenal Ulcer, p. 368, Sept. '25.
- HUBERT, M. A. (and H. W. Birdsong and G. O. Wheelchel), Athens  
Splenic Anemia, p. 453, Nov. '25.

## J

- JARRELL, W. W., Thomasville  
The Attributes of the Heart's Action, p. 227, June '25.
- JONES, JACK W., Atlanta  
Precancerous Dermatoses, p. 189, May '25.
- JORDAN, W. P., Columbus  
Plaque for Persistency in Treatment of Gonorrhea, p. 110, March '25.

## K

- KIRKLAND, S. A., Atlanta  
Advances in Recognition and Treatment of Inflammatory Bladder Diseases, p. 64, Feb. '25.

## L

- LAKE, WM. F. (and Edgar G. Ballenger and Omar F. Elder), Atlanta  
Air Cystograms to Demonstrate Prostatic Enlargements Which Protrude Into the Bladder, p. 99, March '25.
- LANDHAM, J. W., Atlanta  
Opaque and Non-Opaque Foreign Bodies in the Gastro-Intestinal and Respiratory Tracts, p. 237, June '25.
- LEWIS, JOHN R., Louisville  
Breath Sounds Over Mastoid Cells, p. 375, Sept. '25.
- LEWIS, WM. HOWARD, Rome  
Problems of Pathology of the Biliary Tract, p. 400, Oct. '25.

## M

- MATHEWS, W. L., Winder  
Eclampsia, p. 105, March '25.
- MURPHEY, EUGENE E., Augusta  
Bronchial Spirochetosis; Report of Cases, p. 240, June '25.
- MYERS, WILLIAM H., Savannah  
Pelvic Infection in the Female-Review of the Subject, p. 144, April '25.

## Mc

- McCORD, MATHER M., Rome  
Report of 2,000 Infants Fed on Dry Milk, p. 316, Aug. '25.
- McCULLOUGH, KENNETH, Waycross  
Industrial Hernia, p. 61, Feb. '25.
- McDOUGALL, WILLIAM L., Atlanta  
External Pachymeningitis Simulating Purulent Lep-tomeningitis; Report of Case, p. 56, Feb. '25.

## N

- NEAGLE, H. B., Augusta  
Pediatrics and the Public Health, p. 442, Nov. '25.
- NILES, GEO. M., Atlanta  
Rectal Feeding, p. 197, May '25.

## O

- OSBORNE, ELTON S., Savannah  
Tips for the Cock-Sure Specialist, p. 14, Jan. '25.

## P

- PRUITT, M. C., Atlanta  
Choice of Anesthesia in Surgical Operations of the Rectum, p. 490, Dec. '25.

## Q

- QUATTLEBAUM, JULIAN K., Savannah  
Gas Bacillus Infection, p. 139, April '25.

## R

- REYNOLDS, HAROLD I., Athens  
The Treatment of Diabetes Mellitus, p. 187, May '25.
- RICHARDSON, C. H., Jr., Macon  
Intracranial Injuries in the New Born, p. 484, Dec. '25.  
Statewide Health Association, p. 7, Jan. '25.
- ROBERTS, STEWART R., Atlanta  
The Treatment of Pneumonia, p. 113, March '23.
- ROGERS, THOS. E., Macon  
The Treatment of Diabetes and Use of Insulin, p. 230, June '25.

## S

- SELMAN, W. A., Atlanta  
Acute Appendicitis, p. 195, May '25.
- SIMPSON, A. W., Washington  
President's Address (Eighth District), p. 357, Sept. '25.
- SIMPSON, J. R., Gainesville  
The Eye Symptoms of Constitutional Disturbance, p. 199, May '25.
- SLACK, HENRY R., LaGrange  
Myxedema, p. 359, Sept. '25.
- STUKES, J. T., Americus  
Remarks on Diseases of the Prostate, p. 202, May '25.
- SWINT, ROGER C., Milledgeville  
Some Features of the Mental Disease Problem, p. 177, May '25.

## T

- THOMPSON, O. R., Macon  
Anencephalic Monster, p. 283, July '25.
- THORNTON, LAWSON, Atlanta  
The Treatment of Bone and Joint Tuberculosis, p. 89, March '25.
- TOEPEL, THEO., Atlanta  
Extracts from Inaugural Address, p. 153, April '25.

## W

- WAGNON, B. H., Atlanta  
Some Georgia Doctors, p. 153, April '25.
- WALL, C. K., Thomasville  
Ureteral Calculus Bilateral, with Time Check on at Least One Stone, p. 69, Feb. '25.
- WARNSHUIS, F. C., Grand Rapids, Mich.  
A Definite Program for 1925, p. 4, Jan. '25.
- WATT, CHAS. HANSELL, Thomasville  
The Neglected Prostate, p. 67, Feb. '25.
- WEAVER, J. CALVIN, Atlanta  
The Vegetative Nervous System in Health and Disease, p. 45, Feb. '25.
- WHELCHER, C. D., Gainesville  
Frequently Overlooked Conditions of the Urinary Tract, p. 53, Feb. '25.
- WHELCHER, GUY O. (and H. W. Birdsong and M. A. Hubert), Athens  
Splenic Anemia, p. 453, Nov. '25.
- WHIDDON, L. L., Ocilla  
Pellagra and Its Treatment, p. 409, Oct. '25.

# Medical Association of Georgia

Next Annual Meeting, Albany, Ga., May 12, 13, 14, 1926

President-----	Frank K. Boland, Atlanta		
First Vice-President-----	W. R. Dancy, Savannah	Secretary-Treasurer-----	Allen H. Bunce, Atlanta
Second Vice-President-----	H. M. Fullilove, Athens	Parliamentarian-----	M. A. Clark, Macon
Delegate to A. M. A. (1925)		Delegate to A. M. A. (1926)	
A. H. Bunce, Atlanta		R. L. Miller, Waynesboro	
Alternate, W. C. Lyle, Atlanta		Alternate, C. W. Roberts, Atlanta	

## COUNCIL

V. O. Harvard, Chairman-----	Arabi	Allen H. Bunce, Secretary-----	Atlanta
------------------------------	-------	--------------------------------	---------

### Councillors

1. Chas. Usher (1927)-----	Savannah
2. C. K. Sharp (1927)-----	Arlington
3. V. O. Harvard (1927)-----	Arabi
4. O. W. Roberts (1927)-----	Carrollton
5. E. C. Thrash (1928)-----	Atlanta
6. M. M. Head (1928)-----	Zebulon
7. M. M. McCord (1928)-----	Rome
8. Stewart D. Brown (1928)-----	Royston
9. C. D. Whelchel (1926)-----	Gainesville
10. S. J. Lewis (1926)-----	Augusta
11. A. S. M. Coleman (1926)-----	Douglas
12. T. C. Thompson (1926)-----	Vidalia

### Vice-Councillors

1. C. Thompson (1927)-----	Millen
2. R. F. Wheat (1927)-----	Bainbridge
3. J. F. Lunsford (1927)-----	Preston
4. J. A. Thrash (1927)-----	Columbus
5. W. A. Selman (1928)-----	Atlanta
6. J. M. Anderson (1928)-----	Barnesville
7. J. H. Hammond (1928)-----	LaFayette
8. B. C. Teasley (1928)-----	Hartwell
9. W. J. Hutchins (1926)-----	Buford
10. H. D. Allen, Jr. (1926)-----	Milledgeville
11. K. McCullough (1926)-----	Waycross
12. J. Cox Wall (1926)-----	Eastman

## COMMITTEES

### Committee on Scientific Work

W. A. Mulherin, Chairman (1926)-----	Augusta
Frank Bird (1926)-----	Valdosta
A. H. Bunce, Secretary-Treasurer-----	Atlanta

### Committee on Public Policy and Legislation

J. W. Palmer, Chairman (1926)-----	Ailey
W. E. McCurry (1927)-----	Hartwell
B. H. Wagon (1928)-----	Atlanta
Frank K. Boland, President-----	Atlanta
Allen H. Bunce, Secretary-Treasurer-----	Atlanta

### Committee on Medical Defense

M. A. Clark, Chairman (1928)-----	Macon
E. C. Thrash (1926)-----	Atlanta
E. C. Davis (1929)-----	Atlanta
V. O. Harvard, Chairman, Council-----	Arabi
Allen H. Bunce, Secretary-Treasurer-----	Atlanta

### Committee on Hospitals

C. Thompson, Chairman (1926)-----	Millen
R. M. Harbin (1926)-----	Rome
W. H. Myers (1926)-----	Savannah

### Committee on Necrology

L. A. Baker, Chairman (1926)-----	Tifton
L. M. Gable (1926)-----	Griffin
W. H. Clark (1926)-----	LaGrange

### Committee on Health and Public Instruction

Theo. Toepel, Chairman (1926)-----	Atlanta
H. B. Neagle (1928)-----	Augusta
J. A. Thrash (1927)-----	Columbus
Frank K. Boland, President-----	Atlanta
Allen H. Bunce, Secretary-Treasurer-----	Atlanta

### Cancer Commission

J. L. Campbell, Chairman-----	Atlanta
Chas. Usher-----	Savannah
C. H. Watt-----	Thomasville
G. Y. Moore-----	Cuthbert
Frank P. Norman-----	Columbus
A. R. Rozar-----	Macon
W. H. Lewis-----	Rome
J. S. Stewart, Jr.-----	Athens
M. B. Allen-----	Hoschton
E. A. Wilcox-----	Augusta
H. M. Branham-----	Brunswick
T. C. Thompson-----	Vidalia
E. L. Bishop, Pathologist-----	Atlanta

### Committee on National Defense

1. R. E. Graham-----	Savannah
2. H. M. Moore-----	Thomasville
3. Job. C. Patterson-----	Cuthbert
4. W. F. Jenkins-----	Columbus
5. R. R. Daly, Chairman-----	Atlanta
6. Linwood M. Gable-----	Griffin
7. Chas. V. Wood-----	Cedartown
8. Eugene F. Griffith-----	Eatonton
9. John K. Burns-----	Gainesville
10. Francis X. Mulherin-----	Augusta
11. G. T. Crozier-----	Valdosta
12. Ovid H. Cheek-----	Dublin

### Fraternal Delegates to Other State Meetings

To Visit Florida: B. H. Minchew, Waycross;	
Geo. L. Touchton, Savannah.	
To Visit South Carolina: E. E. Murphey, Au-	
gusta; B. C. Teasley, Hartwell.	
To Visit Alabama: J. M. Anderson, Columbus;	
J. W. Landham, Atlanta.	
To Visit Tennessee: H. L. Erwin, Dalton; J. H.	
Hammond, LaFayette.	
To Visit North Carolina: J. H. Downey, Gaines-	
ville; C. L. Ayers, Toccoa.	



## The Tulane University of Louisiana Graduate School of Medicine

Class A-1 school, reorganized to meet all requirements of the Council on Medical Education of the A. M. A. Splendid clinics, wonderful opportunities for both advanced studies leading to a degree as well as short review courses for busy practitioners. Added to this is a mild climate in a most interesting old city. Thirty-ninth session begins November 2, 1925. For further information address,

DEAN, GRADUATE SCHOOL OF MEDICINE  
1515 Canal Street, New Orleans, La.

*Open All the Year  
with Pluto Spring Flowing All the Time*

French Lick, Ind.  
French Lick, Ind.  
Lick  
Springs  
Hotel Co.



No Hospital  
No Sanatorium

### SIX HUNDRED AND FIFTY ROOMS (ALL OUTSIDE) IN OUR HOTEL

A place where your patients can find attractive surroundings with adequate medical service and supervision.

Dunning S. Wilson, M.D., Ky. U. of L., '99, is in charge of the Medical Department, which is equipped with complete X-ray, actinic ray, chemical and bacteriological laboratories for diagnostic and therapeutic work.

When your patients are tired of home or hospital send them to French Lick for final recuperation. Write for Booklet.

### THE LINDORME TRUSS

The success of the Lindorme Spring Wire Truss is due to the detailed accuracy with which each is made and fitted to the individual case.

No stock Trusses kept on hand. Correspondence with Physicians invited.

A. H. LINDORME, M. D.

Suite 216

Physicians Bldg.

41 Forrest Ave., Atlanta, Ga.

Phone Connections.

## DICKS' NUTRITIVE ELIXIR

Contains the highest percentage of proteid of any product of its kind, (4.4%).

Its easily retained by an irritable stomach, when other food is rejected.

Its fine Flavor makes it agreeable to the patient.

All doctors who have tried it speak highly of it.

Put up especially for the practitioner. Regular size, \$1.00 at your drug-gists. For sample, send to

**F. A. Dicks & Company, Inc.**

433 Bourbon St.

New Orleans

### SITUATIONS WANTED

WANTED: Salaried Appointments for Class A physicians in all branches of the Medical Profession. Let us put you in touch with the best man for your opening. Our nation-wide connections enable us to give superior service. Aznoe's National Physicians', Member The Chicago Association of Commerce.









